Mutual of Omaha Insurance Company
Mutual of Omaha Plaza, Omaha, NE 68175

APPLICATION for

ACCIDENT ONLY
DISABILITY INCOME INSURANCE

MICHIGAN

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza, Omaha, NE 68175

✍ Checklist for Submitting a Completed Application

Please mail application and appropriate forms to:
Mutual of Omaha Insurance Company, Attn: Records/Mailing Processing Center, 9330 State Hwy 133, Blair, NE 68008-6179

☐ **Application**

1 Answer all questions completely.
2 Leave all applicable forms with the proposed insured.
3 Sign and Date in all places indicated.
4 See reverse side of this page for detailed information.

☐ **Privacy Authorizations**

The HIPAA and MIB authorizations are to be signed and returned with the application.

☐ **Complete Premium Collection Section**

A full modal premium is collected at the time of application unless the No Cash With App (NCWA) or Bank Service Plan (BSP) is selected.

☐ **Attach Copy of Illustration**

☐ **Submit Financial Requirements**

☐ See DI Choice Product and Underwriting Guide for details.

☐ **Any Additional Information or Comments-**

Include any supplemental information about your client (health, financial, occupational)

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NOTE: BROKERAGE ONLY – Please list your "commission code" in the box on the first page of the application. This will help avoid delay in commission payment.

DO NOT DETACH – MUST BE SUBMITTED WITH THE APPLICATION

There are two parts to this application: One part is the general application. The other part includes necessary administrative forms that you will need at time of sale.

Part 1: APPLICATION

- Notify the applicant that a telephone interview may be conducted to obtain additional information and/or to verify application information.
- Complete application in full and provide details in the areas provided as necessary.

Premium Information- Cash With App Option

- The total premium amount must be listed. The total amount collected must equal the total amount of all Policy Premiums + all Rider Premiums.
- Show the amount collected, modes (annual/semi-annual/quarterly/Individual Bank Service Plan), and amount of initial and renewal premium.
- If BSP, attach check for the account from which premiums will be withdrawn.
- If Payroll Deduction mode, complete the PRD Authorization form.
- The effective date = the application date.

Premium Information- No Cash With App Option

- Available with BSP only.
- The total amount of premiums must be listed.
- Initial premium draft will occur upon policy approval.
- Specify date renewal premiums will be withdrawn.
- Attach check for the account from which premiums will be withdrawn.
- The effective date = the issue date.

Agreements

- The X indicates where the applicant(s) signature is needed.
- Please request the applicant read the entire Agreement section before signing.
- Any alterations to this section will not be accepted.

Part 2: ADMINISTRATIVE FORMS

Authorization to Disclose Personal Information

- The HIPAA authorization is to be signed and returned with the application.

Authorization to Receive Information From and Disclose Information to the MIB Group

- The MIB authorization is to be signed and returned with the application.

Agent/Producer Statement

- This is necessary information for the underwriting process.

Notice of Information Gathering Practices, MIB Group, Inc. Pre-Notice

- Remove notice and provide to proposed insured at time of application. The Notice of Information Practices informs the Proposed Insured that Mutual of Omaha may obtain information about the Proposed Insured from other sources. The MIB Group, Inc. Pre-Notice describes the MIB Group, Inc., the services it provides to members, and the Proposed Insured's rights to request the MIB Group, Inc. to arrange disclosure in accordance with procedures set forth in the Fair Credit Reporting Act.

Receipt and/or Temporary Health and Accident Insurance Agreement

- Detach and leave with proposed insured.

State–Specific Forms – complete if applicable

- Be sure to include all state appropriate forms.

Requirements:

- Submit to Home Office
  - Application (Complete all information in full, sign and date)
  - Signed Conditional Receipt and/or Temporary Health and Accident Insurance Agreement
  - Applicable Administrative Forms
  - Premiums (If Cash With App)
- Leave with Insured
  - Copy of Conditional Receipt and/or Temporary Health and Accident Insurance Agreement
  - Outline of Coverage

NOTE: The following forms can be downloaded from Sales Professional Access (SPA) at www.mutualofomaha.com as needed to accompany the application.

- Replacement Notice
- Drug Questionnaire
- Foreign Travel Questionnaire
- Alcohol Usage Questionnaire
- Avocation Questionnaire

Manager/Commission Code (Required Field for Brokerage)	District Sales Manager/Associate Marketer	Application Reviewed By

Application For:

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175

ACCIDENT ONLY DISABILITY INSURANCE

SECTION A GENERAL INFORMATION - COMPLETE FOR ALL CASES

PROPOSED INSURED INFORMATION

1. Proposed Insured's Name (First, Middle, Last) ______________________
2. Sex ☐ Female ☐ Male
3. Age ______________ DOB ______/______/______
4. Birth State ______________________
5. Social Security Number _________-_________-_________
6. Height (Ft & In) ____________Weight (Lbs) ____________
7. Home Tel. Number (_______) ______________________
   Daytime Tel. Number (_____) ______________________
   Best Time to Call __________ ☐ A.M. ☐ P.M.
8. Legal Residence Address (Number, Street, City, State, Zip) ______________________
9. Mailing Address for Premium Notices (if different than above) ______________________
10. E-Mail Address (optional)______________________
11. Citizenship Status (check one):
    ☐ U.S. Citizen, or
    ☐ Permanent Resident (Form I-551) Cardholder who has resided in the U.S. at least 3 consecutive years. If checked, please complete Foreign Travel Questionnaire.
    ☐ Other (Please explain) ______________________
12. Employer ______________________
    Address ______________________
    Business Phone Number ______________________
    Occupation ______________________
    List exact duties ______________________
13. Are you actively working at least 30 hours per week? ☐ Yes ☐ No
14. How long have you been employed in your current position?
    __________Years _________Months
15. Proposed Insured's Employment Status:
    ☐ Employee (No Ownership)
    ☐ Sole Proprietor
    ☐ Partner in Partnership ___ % Ownership
    ☐ Shareholder in Sub "S" Corp. ___ % Ownership
    ☐ Owner of C – Corp. ___ % Ownership
16. Do you have any part-time or off-season occupation?
    ☐ Yes ☐ No (If "Yes," list exact duties/hours per week) ______________________
17. Are you a member of an approved Association Group or Franchise?
    ☐ Yes ☐ No If "Yes," full name of organization _______
    Date joined (Mo./Yr.)______________________
18. Full name of beneficiary ______________________
    Relationship to Proposed Insured ______________________

OTHER COVERAGE AND REPLACEMENT INFORMATION

1. Are you covered under or eligible for: (Check all that apply)
   The Federal Employee's Compensation Act (FERS or CSRS)? .... ☐ Yes ☐ No
   The Railroad Retirement Act? .... ☐ Yes ☐ No
   Workers Compensation? .... ☐ Yes ☐ No
2. Are you currently applying for, or do you have in force other disability income coverage, such as: (1) Individual Disability Income; (2) Sick Pay, Association, or Group Disability Plan; or (3) Business Expense or Buy/Sell Insurance? ... ☐ Yes ☐ No
   If "Yes," complete the following information:

Company or Source	Pending or Inforce (P/I)	Type (1,2,3)	Benefit Amt. or % of Income	Elim. Period	Benefit Period	% of Premium Paid by Employer	Will coverage be replaced?
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

3. **Complete only if replacing Mutual of Omaha Insurance Company in-force coverage with another Mutual of Omaha Insurance Company policy.**
   I am requesting termination of my Policy No. ______________________
   on the effective date of the new policy for which I am applying. I understand that all benefits under the policy being terminated will cease on the effective date of the new policy. **NOTE:** Benefits for which you apply may not take effect whenever there is duplication of benefits which would result in excess coverage.

Income Information

1. Income information (Attach financial records if required. See underwriting guide for details)

	Current Year	Prior Year
(a) Gross Annual Earned Income	$ ______	$ ______
(b) If **self employed**, net annual earned income from your occupation (after business expenses and before taxes)	$ ______	$ ______
(c) Bonus, First Year Commissions and other incentive payments	$ ______	$ ______
(d) Other Earned Income (Part-time, off-season, etc.)	$ ______	$ ______
Total	$ ______	$ ______

2. During the last 12 months did you receive unearned income (such as dividends, interest, net rentals, pension or renewal commissions) reportable for federal tax purposes or does your tax exempt unearned income exceed $1,500 per month? ☐ Yes ☐ No

   If "Yes," monthly average over last 12 months $ ______

SECTION B Complete only if applying for Accident Only Disability Insurance

1. During the last 5 years, have you been treated for alcoholism or have you used unlawful drugs (such as cocaine, methamphetamine and hallucinogens) or used prescription drugs (such as sedatives, tranquilizers, or narcotics) other than as prescribed? ☐ Yes ☐ No
   (If "Yes," submit a Drug or Alcohol Use Questionnaire)
2. During the last 3 years, have you participated in any hazardous activities more than once, such as motor sports racing, boat racing, rock or mountain climbing, sky diving, hang gliding, skin or scuba diving? ☐ Yes ☐ No
   (If "Yes," submit an Avocation Questionnaire)
3. Other than previously answered, during the last 3 years have you received, or been advised by a healthcare provider (including chiropractor) to receive, diagnostic testing or treatment for any chronic medical condition, medical impairment or disability? ☐ Yes ☐ No
   If "Yes," give details below. (Attach a separate signed sheet if necessary.)

Diagnosis of injury, disability or impairment	Month and Year	Details of Treatment	Was surgery performed?	Degree of recovery	Name and address of doctor/hospital
			☐Yes ☐No		
			☐Yes ☐No		
			☐Yes ☐No		

SECTION E PLAN INFORMATION

Accident Only Disability Insurance

Monthly Benefit Amount $______

Elimination Period: ☐ 0 Days ☐ 7 Days ☐ 14 Days ☐ 30 Days ☐ 60 Days ☐ 90 Days

Benefit Period: ☐ 3 Months ☐ 6 Months ☐ 12 Months ☐ 24 Months

Optional Riders:

☐ Hospital Confinement Accident Indemnity Benefits Rider ☐ $125 ☐ $250 ☐ $350 ☐ $500

☐ Accident Medical Expense Rider

Maximum Benefit: ☐ $1,000 ☐ $2,000 ☐ $3,000 ☐ $5,000

SECTION F PREMIUM COLLECTION

Billing Options:

1. No Cash With App (Effective Date = Issue Date)

☐ BSP

2. Cash With App (Effective Date = Application Date)

Initial Premium Collected $______________ Renewal Premium $______________

☐ BSP (If BSP is selected, collect 2 months of premium.)
☐ Quarterly
☐ Semiannual
☐ Annual

3. Payroll Deduction (only available with Accident Only plan)

Add to Existing PRD – Group Number.. ____________________________
First Deduction Date .... ____________________________
Number of Deductions... ____________________________
Effective Date .... ____________________________

SECTION G Complete only if Billing Mode is BSP

AUTHORIZATION TO WITHDRAW FUNDS BY MUTUAL OF OMAHA INSURANCE COMPANY ("MUTUAL OF OMAHA")

I authorize Mutual of Omaha to withdraw funds from my account for my initial and/or renewal premiums and understand that the amounts may differ. I also authorize Mutual of Omaha to collect any premium(s) due by bank draft withdrawal. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize you, my financial institution, to pay from my account any checks, drafts or preauthorized electronic fund transfers from my account to Mutual of Omaha. Your rights with each charge will be the same as if personally paid by me. This authorization will be effective until I give you at least three business days' notice to cancel it. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

1. Specify the date the premiums will be withdrawn: ☐ 1st of the Month or ☐ 15th of the Month

2. Attach your check from the account from which premiums will be withdrawn or provide routing and account number.

Routing Number ____________________________________ Account Number ______________________________________

SECTION H PLEASE READ AND SIGN

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

I authorize physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations, MIB (Medical Information Bureau), insurers, employers, consumer reporting agencies and any other organization, institution, or person that has records or knowledge of me or my health to release personal information about me to Mutual of Omaha Insurance Company or its affiliated companies (Mutual).

Personal information includes my health information such as medical history, mental or physical condition, prescription drug records, drug or alcohol use and other information such as finances, occupation, general reputation and insurance claims information. The personal information may include my entire medical record.

The Personal information will be used to determine my eligibility for insurance or to resolve or contest any issues of incomplete, incorrect or misrepresented information on the application that may arise during the processing of my application or in connection with a claim.

I also authorize Mutual to disclose my personal information to the MIB. I understand that my personal information received by the MIB may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits.

If the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the information may be redisclosed without the protection of the federal privacy regulations.

I understand that I may refuse to sign this authorization. I realize if I refuse to sign, the insurance for which I am applying will not be issued.

This authorization will expire 24 months after the date signed. I may revoke this authorization at any time by written notice to ATTN: Individual Underwriting, Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175. This revocation is limited to the extent that Mutual has taken action in reliance on the authorization or the law allows Mutual to contest the issuance of the policy or a claim under the policy. I understand that I will receive a copy of this authorization and that a copy is as valid as the original.

AGREEMENTS AND ACKNOWLEDGEMENTS

1. The undersigned applicant agrees that (a) all answers in this application are true and complete and Mutual of Omaha Insurance Company will rely on these answers to determine insurability, and (b) incorrect or misleading answers may void this application and any policy Issued from its effective date.

2. Applicant acknowledges that Mutual of Omaha Insurance Company may require: medical records, an underwriting assessment, a medical examination, or other information.

3. Applicant agrees that Mutual of Omaha Insurance Company will not issue a policy as a result of this application unless (a) the insurance applicant completes all medical examinations and tests required by Mutual of Omaha Insurance Company, (b) Mutual of Omaha Insurance Company receives any additional information requested for underwriting, and (c) the insurance applicant is, as of the policy application date, determined to be eligible for the exact insurance applied for, or the insurance applicant has subsequently accepted an offer by Mutual of Omaha Insurance Company for coverage other than as applied for, according to the underwriting standards of Mutual of Omaha Insurance Company then in force.

4. Applicant agrees that this application does not provide temporary or interim insurance prior to policy issuance. If the applicant has made an advance premium payment, applicant agrees to the terms and conditions of the Conditional Receipt. Applicant agrees that completing this application or making an advance premium payment is not a guarantee that this application will be approved. If approved, the issued policy will indicate its effective date. Applicant acknowledges that if his or her application is declined, the insurance coverage applied for will not become effective and any advance premium payment submitted with the application will be refunded to applicant, without interest. No insurance coverage will be in effect until Mutual of Omaha Insurance Company (a) issues a policy and (b) receives payment of the full initial premium according to the mode of payment specified in the application.

5. Applicant acknowledges that no producer can (a) waive or change any receipt or policy provision, or (b) agree to issue a policy.

SECTION H — PLEASE READ AND SIGN - continued

I have (a) read and understand the Authorization to Disclose Personal Information and Agreement Section; (b) read and approved the answers as recorded on this application; and (c) received the appropriate Outline/Summary of Coverage.

Signed at: ______________________________ ______________________________
City State Date

______________________________ ______________________________ ______________________________
Signature of Proposed Insured Printed Name of Proposed Insured Date

______________________________ ______________________________ ______________________________
Signature of Payor as shown on bank account Printed Name of Payor Date
(if Billing Mode is BSP and Payor is other than Proposed Insured)

I/We certify that during an interview with the Proposed Insured(s), I/we asked each question exactly as written and recorded the answers provided by the Proposed Insured(s) completely and accurately. . . . . ☐ Yes ☐ No

(If "No," please explain.)______________________________

I conducted said interview in person ☐ Yes ☐ No

(If "No," please explain.)______________________________

______________________________ ______________________________ ______________________________
Signature of Producer Producer's Printed Name Date

______________________________ ______________________________
Office Name Office Address

______________________________ ______________________________ ______________________________
Signature of Producer Producer's Printed Name Date

______________________________ ______________________________
Office Name Office Address

Michigan – Authorization To Disclose Personal Information To Mutual of Omaha Insurance Company

Meanings of Terms

"Medical Persons and Entities" means: all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services.

"Personal Information" means: all health information, such as medical history, mental and physical condition, including the presence of HIV infection, AIDS or ARC, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me and, if my children are proposed insureds, my children also. Personal Information does not include Psychotherapy Notes.

"Psychotherapy Notes" means: notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person's medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.

"Specified Companies" means:

- The group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, United World Life Insurance Company, Companion Life Insurance Company, additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

Authorization to Disclose

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me and, if my children are proposed insureds, about my children to Mutual of Omaha Insurance Company.

Purposes

The Personal Information will be used to determine my or my children's eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application which may arise during the processing of my application or in connection with claims for insurance benefits.

Potential for Redisclosure

If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.

Failure to Sign

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.

Expiration and Revocation

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to:

ATTN: Individual Underwriting
Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175-0001

I realize that my right to revoke this authorization is limited to the extent that Mutual of Omaha Insurance Company has taken action in reliance on the authorization or the law allows Mutual of Omaha Insurance Company to contest the issuance of the policy or a claim under the policy.

Copy

I understand that I will receive a copy of the signed authorization. A copy of this authorization is as effective as the original.

Names and Signatures

Name(s) used for medical records (if different than the name(s) below): ______________________________

______________________	______________________	______________________
Printed Name of Proposed Insured	Spouse's Printed Name (If Proposed Insured)	If children are to be insured, their printed names
______________________	______________________	______________________
Signature of Proposed Insured	Signature of Spouse (If Proposed Insured)	Signature of Parent or Guardian (If Proposed Insured is a Minor)
______________________	______________________	______________________
Date	Date	Date

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

Authorization to Receive Information From and Disclose Information to the MIB Group, Inc. ("MIB")

Meanings of Terms

"MIB Group, Inc. (MIB)" means: a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

"Personal Information" means: all health information, such as medical history, mental and physical condition, including the presence of HIV infection, AIDS or ARC, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me and, if my children are proposed insureds, my children also.

"Specified Companies" means:

- The group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, Companion Life Insurance Company, additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

Authorization to Receive and Disclose

To the MIB:

I authorize you to disclose Personal Information about me (the undersigned) or my children to the Specified Companies and their reinsurers. You are not authorized to disclose information about me to a consumer reporting agency. Information received will assist in verifying the accuracy of the information I have provided in my application(s) for insurance with one or more of the Specified Companies.

I also authorize the Specified Companies and their reinsurers to disclose Personal Information about me or my children to the MIB. I understand that the Personal Information received by the MIB may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to:

Attn: Individual Underwriting
Mutual of Omaha
Mutual of Omaha Plaza
Omaha, NE 68175-0001

I also understand that any revocation of this authorization will not affect any use or disclosure of Personal Information that occurred prior to the receipt of my revocation.

I have been advised that I, or my authorized representative, am entitled to receive a copy of this authorization. A copy of this authorization is as effective as the original.

Name(s) used for medical records (if different than the name(s) below): ______________________________

____

____

______________________________ Signature of Proposed Insured ______________ Date

______________________________ Signature of Spouse (If Proposed Insured) ______________ Date

______________________________ Signature of Parent or Guardian (If Proposed Insured is a Minor) ______________ Date

Agent/Producer Statement

1 Do you have any reason to believe the policy applied for has replaced or will replace any existing disability income insurance? (If "Yes," fulfill all state requirements.)........ ☐ Yes ☐ No

2 Has a medical examination of the Proposed Insured been scheduled?........ ☐ Yes ☐ No

If "Yes," when? ______________________ By ______________________

3 Has the client profile interview been completed?........ ☐ Yes ☐ No

If "No," the client profile interview has been scheduled for __________ (Date) and ______________ (Time (Please circle –Eastern, Central, Mountain or Pacific))

4 Did you give the Notice of Information Practices to the Proposed Insured?........ ☐ Yes ☐ No

Date ______________ (Mo. Day Yr.) ______________________ Agent/Producer's Signature ______________________ Agent/Producer's Signature

Agent/Producer Information:

Agent/Producer Name ______________________ Agent/Producer Social Security Number ______________

Comm. % Share ______________________ Agent/Producer Phone Number (______) (Area Code) ______________

Agent/Producer E-mail Address ____

Agent/Producer's Stamp ______________________ Agent/Producer's License/ID Number ______________

Agent/Producer Name ______________________ Agent/Producer Social Security Number ______________

Comm. % Share ______________________ Agent/Producer Phone Number (______) (Area Code) ______________

Agent/Producer E-mail Address ____

Agent/Producer's Stamp ______________________ Agent/Producer's License/ID Number ______________

Mutual of Omaha Insurance Company
Notice of Information Practices

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. Upon request, you have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge you to review your application carefully to be sure the answers are correct and complete.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: MUTUAL OF OMAHA INSURANCE COMPANY, DIRECTOR OF INDIVIDUAL UNDERWRITING, MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175.

M26977

Mutual of Omaha Insurance Company
MIB Group, Inc. Pre-Notice

Information regarding your insurability will be treated as confidential. Mutual of Omaha Insurance Company or its reinsurers may make a brief report to the MIB Group, Inc. (MIB), a nonprofit membership organization of insurance companies which operates an information exchange for its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply the information in its file to that company.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734

In compliance with applicable law, Mutual of Omaha Insurance Company, or its reinsurers, may also release information in its file, including information given in your application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted. **Information for consumers about MIB may be obtained on its website at www.mib.com.**

M26978_0809

Remove Notices and Give to Proposed Insured

Conditional Receipt

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175

☐ **Initial Premium paid by check**
Money was collected - Received $____________________ from ______________________ paid with an insurance application on ____, dated ____________________ .
(person(s) proposed for insurance)

(ALL CHECKS FOR PREMIUMS MUST BE MADE PAYABLE TO MUTUAL OF OMAHA INSURANCE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.)

This Conditional Receipt will provide limited insurance coverage for each person proposed for insurance, subject to all of the provisions of the policy(ies) applied for, as of the application date, but only if all of the following conditions have been completely met:

1. Written application.
2. Payment of the full initial premium.
3. Completion by the Proposed Insured of all examinations and tests (medical, paramedical, laboratory) required by Mutual of Omaha Insurance Company.
4. Receipt by Mutual of Omaha Insurance Company of any additional information (such as an Attending Physician's Statement) requested for underwriting.
5. Satisfying Mutual of Omaha Insurance Company underwriting standards.

If (a) any of the above conditions are not exactly met, or (b) the above conditions are exactly met but the person proposed for insurance dies by suicide, whether sane or insane (except in Colorado and Missouri), or (c) the application is not accepted by Mutual of Omaha, no insurance coverage will be provided under this Conditional Receipt, and Mutual of Omaha's only liability will be to notify the applicant in writing and return the premium paid.

For each person proposed for insurance, the maximum benefit payable under this Conditional Receipt will be the lesser of: (a) the total benefit payable under all pending applications with Mutual of Omaha relating to the person proposed for insurance, or (b) $50,000. This Receipt provides no coverage for policy Riders.

Regardless of any other provision of this Conditional Receipt, any coverage that becomes effective under this Conditional Receipt will terminate on the earliest of the following: (a) the effective date of a policy issued as a result of this application; (b) the date Mutual of Omaha mails notice that the coverage applied for will not be issued and refunds any premium paid; or (c) 60 days following the date of the application. Either Mutual of Omaha or the person proposed for insurance may terminate this Conditional Receipt as to such person by providing written notice to the other party.

If you are eligible, the effective date of the insurance will be the date of the application, or the date the number of applications received from members of your group meets the minimum participation requirements, whichever date is later. **If you are not eligible, no insurance or temporary or interim insurance of any kind will be in effect.**

In no event will benefits be paid for the same loss under both this Conditional Receipt and any insurance policy issued from the application.

No producer is authorized to alter the terms of this Receipt, waive any representations, or pass on insurability.

I understand and agree to the terms, conditions and limitations of this Conditional Receipt and the Agreement section of the application. These have been fully explained to me by the Producer.

Date: ________________________________ Signed at: ________________________________
City State

____
Signature of Proposed Insured

________________________________ ________________________________
Signature of Producer Signature of Producer

Conditional Receipt

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175

☐ **Initial Premium paid by check**
Money was collected - Received $____________________ from ______________________ paid with an insurance application on ____, dated ____________________ .
(person(s) proposed for insurance)

(ALL CHECKS FOR PREMIUMS MUST BE MADE PAYABLE TO MUTUAL OF OMAHA INSURANCE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.)

This Conditional Receipt will provide limited insurance coverage for each person proposed for insurance, subject to all of the provisions of the policy(ies) applied for, as of the application date, but only if all of the following conditions have been completely met:

1. Written application.
2. Payment of the full initial premium.
3. Completion by the Proposed Insured of all examinations and tests (medical, paramedical, laboratory) required by Mutual of Omaha Insurance Company.
4. Receipt by Mutual of Omaha Insurance Company of any additional information (such as an Attending Physician's Statement) requested for underwriting.
5. Satisfying Mutual of Omaha Insurance Company underwriting standards.

If (a) any of the above conditions are not exactly met, or (b) the above conditions are exactly met but the person proposed for insurance dies by suicide, whether sane or insane (except in Colorado and Missouri), or (c) the application is not accepted by Mutual of Omaha, no insurance coverage will be provided under this Conditional Receipt, and Mutual of Omaha's only liability will be to notify the applicant in writing and return the premium paid.

For each person proposed for insurance, the maximum benefit payable under this Conditional Receipt will be the lesser of: (a) the total benefit payable under all pending applications with Mutual of Omaha relating to the person proposed for insurance, or (b) $50,000. This Receipt provides no coverage for policy Riders.

Regardless of any other provision of this Conditional Receipt, any coverage that becomes effective under this Conditional Receipt will terminate on the earliest of the following: (a) the effective date of a policy issued as a result of this application; (b) the date Mutual of Omaha mails notice that the coverage applied for will not be issued and refunds any premium paid; or (c) 60 days following the date of the application. Either Mutual of Omaha or the person proposed for insurance may terminate this Conditional Receipt as to such person by providing written notice to the other party.

If you are eligible, the effective date of the insurance will be the date of the application, or the date the number of applications received from members of your group meets the minimum participation requirements, whichever date is later. **If you are not eligible, no insurance or temporary or interim insurance of any kind will be in effect.**

In no event will benefits be paid for the same loss under both this Conditional Receipt and any insurance policy issued from the application.

No producer is authorized to alter the terms of this Receipt, waive any representations, or pass on insurability.

I understand and agree to the terms, conditions and limitations of this Conditional Receipt and the Agreement section of the application. These have been fully explained to me by the Producer.

Date: ________________________________ Signed at: ______________________________________
City State

____
Signature of Proposed Insured

________________________________ ________________________________
Signature of Producer Signature of Producer

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza, Omaha, NE 68175, 402-342-7600

Accident-Only Short-Term Disability Income Insurance Coverage – Outline of Coverage

This Policy Covers Accidents Only
It Does Not Pay Benefits For Loss Resulting From Sickness

For Policy Form D83-20900 and D83-20901

Read Your Policy Carefully

This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Accident Disability Income Insurance Coverage

Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident ONLY, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

Total Disability Benefits

If you are Totally Disabled because of an injury, we will pay the Total Disability Monthly Benefit. Total Disability benefits begin after the Elimination Period has been satisfied. Benefits are payable while you remain Totally Disabled for as long as the Benefit Period.

Partial Disability Benefits

If you are Partially Disabled because of an Injury, we will pay 50% of the Total Disability Monthly Benefit. Partial Disability benefits begin after the Elimination Period has been satisfied. Benefits are payable while you remain Partially Disabled for the lesser of six months or the balance of the Benefit Period.

Presumptive Total Disability Benefits

We will automatically pay Total Disability Benefits for the full length of the Benefit Period upon proof of your presumptive Total Disability. Benefits are payable even if you return to work at any occupation. The Elimination Period will be waived. Regular Medical Care will not be required. You will be presumed to be permanently Totally Disabled if an Injury results in the complete and irrecoverable loss of your:

(a) speech;

(b) hearing in both ears;

(c) sight in both eyes; or

(d) the use of both hands, both feet or one hand and one foot.

Survivor Benefit

Upon your death, we will pay a survivor benefit to your designated Beneficiary, if Total or Proportionate Disability benefits were payable; and the Benefit Period was not exhausted.

Guaranteed Renewable to Age 67

You are guaranteed the right to continue your coverage until Age 67. During that time, we cannot cancel your policy as long as you pay the required premium when it is due.

Premium Changes

Your policy's premium may change, but only if the same change is made to all policies of this form issued to persons of the same Class. We will give you at least 45 days advance written notice before any premium change. In no event will the premium increase during the first 12 months following the Policy Date.

Exclusions

We will not pay benefits for:

(a) loss that begins while this policy is not in force;

(b) loss resulting from an act of declared or undeclared war;

(c) loss sustained while serving in the armed forces (upon notice to us of entry into the armed forces, the unearned portion of the premium will be refunded);

(d) loss caused by intentionally self-inflicted injury (while sane in Colorado);

(e) loss resulting from commission or attempted commission of a felony;

(f) loss caused by suicide or attempted suicide, while sane or insane (sane only in Colorado and Missouri);

(g) loss resulting from your being legally intoxicated or under the influence of an illegal substance or a narcotic (except for narcotics given on the advice of and taken as prescribed by a Physician); or

(h) loss resulting directly or indirectly from disease or bodily infirmity;

Benefits Reduction When Association Group Membership or Self-Employment Ends

(Policy Form D83-20901 Only)

This policy form was issued to you because you are self-employed or a member of a franchise/association group. If your franchise/association membership ends, the organization ceases to endorse this product, or you stop being self-employed, you may continue this coverage. Premiums will not increase as a result of this change. However, all benefits payable for loss beginning after such time will be reduced by 15%.

Workers' Compensation Limitation

Benefits payable for loss for which benefits are provided under any state or federal workers' compensation, employer's liability, or occupational disease law will be reduced by 50%.

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza, Omaha, NE 68175

APPLICATION for

DISABILITY INCOME CHOICE PORTFOLIO INSURANCE

MICHIGAN

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza, Omaha, NE 68175

✍ Checklist for Submitting a Completed Application

Please mail application and appropriate forms to:
Mutual of Omaha Insurance Company, Attn: Records/Mailing Processing Center, 9330 State Hwy 133, Blair, NE 68008-6179

☐ **Application**

1. Answer all questions completely.
2. Leave all applicable forms with the proposed insured.
3. Sign and Date in all places indicated.
4. See reverse side of this page for detailed information.

☐ **Privacy Authorizations**

The HIPAA and MIB authorizations are to be signed and returned with the application.

☐ **Complete Premium Collection Section**

A full modal premium is collected at the time of application unless the No Cash With App (NCWA) or Bank Service Plan (BSP) is selected.

☐ **Attach Copy of Illustration**

☐ **Schedule Paramed Exam as Applicable**

American Para Professional Systems (APPS) 1-800-635-1677
Hooper Holmes (Portamedic) 1-800-765-1010
ExamOne 1-877-933-9261
Examination Management Services, Inc (EMSI) 1-800-872-3674
Superior Mobile Medics 1-800-898-3926

☐ **Initiate the Client Profile process with the Proposed Insured- Call 1-800-775-3000 (if applicable)**

☐ **Indicate Underwriting Requirements Initiated or Completed**

☐ Client Profile Interview	☐ MD Exam
☐ Blood Profile	☐ EKG
☐ Physical Data	☐ Mammogram
☐ Long Form	☐ Urinalysis

☐ **Submit Financial Requirements**

☐ See DI Choice Product and Underwriting Guide for details.

☐ **Any Additional Information or Comments-**

Include any supplemental information about your client (health, financial, occupational)

____
____
____
____

NOTE: BROKERAGE ONLY – Please list your “commission code” in the box on the first page of the application. This will help avoid delay in commission payment.

DO NOT DETACH – MUST BE SUBMITTED WITH THE APPLICATION

There are two parts to this application: One part is the general application. The other part includes necessary administrative forms that you will need at time of sale.

Part 1: APPLICATION

- Notify the applicant that a telephone interview may be conducted to obtain additional information and/or to verify application information.
- Complete application in full and provide details in the areas provided as necessary.

Premium Information- Cash With App Option

- The total premium must be listed. The total amount collected must equal the total of all Policy Premiums + all Rider Premiums.
- Show the amount collected, modes (annual/semi-annual/quarterly/Individual Bank Service Plan), and initial and renewal premium.
- If BSP, attach check for the account from which premiums will be withdrawn.
- If PRD mode, complete the PRD Authorization form.
- The effective date = the application date.

Premium Information- No Cash With App Option

- Available with BSP only.
- The total amount of premiums must be listed.
- Initial premium draft will occur upon policy approval.
- Specify date renewal premiums will be withdrawn.
- Attach check for the account from which premiums will be withdrawn.
- The effective date = the issue date.

Agreements

- The X indicates where the applicant(s) signature is needed.
- Please request the applicant read the entire Agreement section before signing.
- Any alterations to this section will not be accepted.

Part 2: ADMINISTRATIVE FORMS

Authorization to Disclose Personal Information

- The HIPAA authorization is to be signed and returned with the application.

Authorization to Receive Information From and Disclose Information to the MIB Group

- The MIB authorization is to be signed and returned with the application.

Agent/Producer Statement

- This is necessary information for the underwriting process.

Notice of Information Gathering Practices, MIB Group, Inc. Pre-Notice

- Remove notice and provide to proposed insured at time of application. The Notice of Information Practices informs the Proposed Insured that Mutual of Omaha may obtain information about the Proposed Insured from other sources. The MIB Group, Inc. Pre-Notice describes the MIB Group, Inc., the services it provides to members, and the Proposed Insured's rights to request the MIB Group, Inc. to arrange disclosure in accordance with procedures set forth in the Fair Credit Reporting Act.

Receipt and/or Temporary Health and Accident Insurance Agreement

- Detach and leave with proposed insured.

State–Specific Forms – complete if applicable

- Be sure to include all state appropriate forms.

HIV Consent Form – complete if applicable

- Form must be signed and dated. Detach 1st copy and leave with Proposed Insured.

Requirements:

- Submit to Home Office
  - Application (Complete all information in full, sign and date)
  - Signed Conditional Receipt and/or Temporary Health and Accident Insurance Agreement
  - Applicable Administrative Forms
  - Premiums (If Cash With App)
- Leave with Insured
  - Copy of Conditional Receipt and/or Temporary Health and Accident Insurance Agreement
  - Outline of Coverage

NOTE: The following forms can be downloaded from Sales Professional Access (SPA) at www.mutualofomaha.com as needed to accompany the application.

- Replacement Notice
- Drug Questionnaire
- Foreign Travel Questionnaire
- Alcohol Usage Questionnaire
- Avocation Questionnaire

Manager/Commission Code (Required Field for Brokerage)	District Sales Manager/Associate Marketer	Application Reviewed By

Application For:

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175

☐ Accident Only Disability Insurance
☐ Short-term Disability Insurance
☐ Long-Term Disability Insurance
☐ Business Operating Expense Disability Insurance

SECTION A GENERAL INFORMATION - COMPLETE FOR ALL CASES

Proposed Insured Information

1. Proposed Insured's Name (First, Middle, Last) ____________
2. Sex ☐ Female ☐ Male
3. Age ________ DOB ____/____/____
4. Birth State ____________
5. Social Security Number _____-_____-_____
6. Height (Ft & In) ______ Weight (Lbs) ______
7. Home Tel. Number (____) ____________
   Daytime Tel. Number (____) ____________
   Best Time to Call ______ ☐ A.M. ☐ P.M.
8. Legal Residence Address (Number, Street, City, State, Zip) ____________
9. Mailing Address for Premium Notices (if different than above) ____________
10. E-Mail Address (optional) ____________
11. Citizenship Status (check one):
    ☐ U.S. Citizen, or
    ☐ Permanent Resident (Form I-551) Cardholder who has resided in the U.S. at least 3 consecutive years. If checked, please complete Foreign Travel Questionnaire.
    ☐ Other (Please explain) ____________
12. Employer ____________
    Address ____________
    Business Phone Number ____________
    Occupation ____________
    List exact duties ____________
13. Are you actively working at least 30 hours per week? ☐ Yes ☐ No
14. How long have you been employed in your current position?
    ______ Years ______ Months
15. Proposed Insured's Employment Status:
    ☐ Employee (No Ownership)
    ☐ Sole Proprietor
    ☐ Partner in Partnership ___ % Ownership
    ☐ Shareholder in Sub "S" Corp. ___ % Ownership
    ☐ Owner of C – Corp. ___ % Ownership
16. Do you have any part-time or off-season occupation?
    ☐ Yes ☐ No (If "Yes," list exact duties/hours per week) ____________
17. Are you a member of an approved Association Group or Franchise?
    ☐ Yes ☐ No If "Yes," full name of organization ____________
    Date joined (Mo./Yr.) ____________
18. Full name of beneficiary ____________
    Relationship to Proposed Insured ____________

Other Coverage and Replacement Information

1. Are you covered under or eligible for: (Check all that apply)
   The Federal Employee's Compensation Act (FERS or CSRS)? .... ☐ Yes ☐ No
   The Railroad Retirement Act? .... ☐ Yes ☐ No
   Workers Compensation? .... ☐ Yes ☐ No
2. Are you currently applying for, or do you have in force other disability income coverage, such as: (1) Individual Disability Income; (2) Sick Pay, Association, or Group Disability Plan; or (3) Business Expense or Buy/Sell Insurance? ... ☐ Yes ☐ No
   If "Yes," complete the following information:

Company or Source	Pending or Inforce (P/I)	Type (1,2,3)	Benefit Amt. or % of Income	Elim. Period	Benefit Period	% of Premium Paid by Employer	Will coverage be replaced?
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

3. **Complete only if replacing Mutual of Omaha Insurance Company in-force coverage with another Mutual of Omaha Insurance Company policy.**
   I am requesting termination of my Policy No. ____________
   on the effective date of the new policy for which I am applying. I understand that all benefits under the policy being terminated will cease on the effective date of the new policy. **NOTE:** Benefits for which you apply may not take effect whenever there is duplication of benefits which would result in excess coverage.

Income Information

1. Income information (Attach financial records if required. See underwriting guide for details)

	Current Year	Prior Year
(a) Gross Annual Earned Income	$ ______	$ ______
(b) If **self employed**, net annual earned income from your occupation (after business expenses and before taxes)	$ ______	$ ______
(c) Bonus, First Year Commissions and other incentive payments	$ ______	$ ______
(d) Other Earned Income (Part-time, off-season, etc.)	$ ______	$ ______
Total	$ ______	$ ______

2. During the last 12 months did you receive unearned income (such as dividends, interest, net rentals, pension or renewal commissions) reportable for federal tax purposes or does your tax exempt unearned income exceed $1,500 per month? ☐ Yes ☐ No

   If "Yes," monthly average over last 12 months $ ______

SECTION B Complete only if applying for Accident Only Disability Insurance

1. During the last 5 years, have you been treated for alcoholism or have you used unlawful drugs (such as cocaine, methamphetamine and hallucinogens) or used prescription drugs (such as sedatives, tranquilizers, or narcotics) other than as prescribed? ☐ Yes ☐ No
   (If "Yes," submit a Drug or Alcohol Use Questionnaire)
2. During the last 3 years, have you participated in any hazardous activities more than once, such as motor sports racing, boat racing, rock or mountain climbing, sky diving, hang gliding, skin or scuba diving? ☐ Yes ☐ No
   (If "Yes," submit an Avocation Questionnaire)
3. Other than previously answered, during the last 3 years have you received, or been advised by a healthcare provider (including chiropractor) to receive, diagnostic testing or treatment for any chronic medical condition, medical impairment or disability? ☐ Yes ☐ No
   If "Yes," give details below. (Attach a separate signed sheet if necessary.)

Diagnosis of injury, disability or impairment	Month and Year	Details of Treatment	Was surgery performed?	Degree of recovery	Name and address of doctor/hospital
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		

SECTION C Complete only if applying for SHORT-TERM DISABILITY, or LONG-TERM DISABILITY or BUSINESS OPERATING EXPENSE Insurance.

1. During the last 10 years, have you received medical care for or had any disease or disorder associated with the following? Check all that apply. Provide explanation for all checked boxes in number 10.

- ☐ Kidney or Urinary Tract
- ☐ Cancer or Tumor
- ☐ Heart or Coronary Arteries
- ☐ Liver or Hepatitis
- ☐ Stroke or Cerebral Vascular condition
- ☐ Diabetes or Glandular condition
- ☐ Psychological, Emotional or Psychiatric condition
- ☐ Upper or Lower Digestive Tract
- ☐ Spine, Neck or Back
- ☐ High Blood Pressure, Peripheral Vascular Disease
- ☐ Arthritis or Joints (including replacements)
- ☐ Anemia or Blood
- ☐ Lung or Breathing Problem
- ☐ Breast or Male/Female Reproductive Organs (such as implants, infertility, irregular menstruation, complication of pregnancy)
- ☐ Neurological condition (such as Multiple Sclerosis, Parkinson's, seizures, Alzheimer's)
- ☐ Chronic Fatigue Syndrome
- ☐ Skin or Connective Tissue
- ☐ Fibromyalgia or Myalgia
- ☐ **None of These**

SECTION C Complete only if applying for SHORT-TERM DISABILITY, or LONG-TERM DISABILITY or BUSINESS OPERATING EXPENSE Insurance. - continued

2. Have you been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV) infection (symptomatic or asymptomatic)? .... ☐ Yes ☐ No

3. During the last 6 months, have you (a) been prescribed medication(s), or (b) taken any medication(s) prescribed by a physician, or (c) regularly used over-the-counter medication(s)? .... ☐ Yes ☐ No
If "Yes," please list below. (Attach a separate signed sheet if necessary.)

Medication Name
Dosage/Frequency
Date
Reason
Prescribing Physician / Address
Phone Number

4. During the last 12 months, have you used any form of tobacco or any form of nicotine replacement therapy (such as nicotine gum, patch or spray)? .... ☐ Yes ☐ No

5. During the last 10 years, have you been treated for alcoholism or have you used unlawful drugs (such as cocaine, methamphetamines and hallucinogens) or used prescription drugs (such as sedatives, tranquilizers, or narcotics) other than as prescribed? .... ☐ Yes ☐ No
(If "Yes," submit a Drug or Alcohol Use Questionnaire)

6. During the last 3 years, have you participated in any hazardous activities more than once, such as motor sports racing, boat racing, rock or mountain climbing, sky diving, hang gliding, skin or scuba diving? .... ☐ Yes ☐ No
(If "Yes," submit an Avocation Questionnaire)

7. Have you: (a) ever been declined, postponed, limited or asked to pay an extra premium for disability benefits by any insurance company? .... ☐ Yes ☐ No
If "Yes," provide details/date ____________________

(b) ever applied for or received disability benefits of any kind?.. ☐ Yes ☐ No
If "Yes," provide details/date ____________________

8. Are you pregnant?....................................... ☐ Yes ☐ No

9. Other than previously answered, during the last 5 years have you received, or been advised by a healthcare provider (including chiropractor) to receive, diagnostic testing or treatment for any chronic medical condition, medical impairment or disability?.............................. ☐ Yes ☐ No

10. Complete this section to expand on questions 1 through 9 in Section C. (Attach a separate signed sheet if necessary.)

Condition, Injury, Symptom of Ill Health or Findings of Examination (If operation is performed, state type)	Month and Year	Duration of the Condition	Degree of Recovery	Name, Address, ZIP and Telephone Number of Hospital, and/or Attending Physician

SECTION D Complete only if applying for BUSINESS OPERATING EXPENSE Insurance

1. Is your business conducted at your place of residence? .... ☐ Yes ☐ No
If "Yes," what percent of your duties are performed outside of your place of residence? .... ________ %

2. Date business established?.. ____/____/____

3. What average monthly operating expenses do you incur (or your portion if a joint tenant) for the following? (Use the average monthly operating expenses incurred for the preceding 12 months.)

Average Monthly Expenses:

No. of employees	________
Employees' salaries	$ ________
Interest on loans	$ ________
Mortgage interest payments	$ ________
Insurance (casualty/liability)	$ ________
Property taxes (real and personal)	$ ________
Depreciation (office equipment only)	$ ________
Rent (including land rental)	$ ________
Electricity	$ ________
Heat	$ ________
Water	$ ________
Telephone	$ ________
Postage and stationery	$ ________
Equipment rental	$ ________
Laundry	$ ________
Other fixed operating expenses (please itemize)	
________	$ ________
________	$ ________
Total Monthly Expenses	$ ________

SECTION E PLAN INFORMATION

Accident Only Disability Insurance

Monthly Benefit Amount $___________________

Elimination Period: ☐ 0 Days ☐ 7 Days ☐ 14 Days ☐ 30 Days ☐ 60 Days ☐ 90 Days

Benefit Period: ☐ 3 Months ☐ 6 Months ☐ 12 Months ☐ 24 Months

Optional Riders:
☐ Hospital Confinement Accident Indemnity Benefits Rider ☐ $125 ☐ $250 ☐ $350 ☐ $500
☐ Accident Medical Expense Rider
Maximum Benefit: ☐ $1,000 ☐ $2,000 ☐ $3,000 ☐ $5,000

Short-Term Disability Insurance

Monthly Benefit Amount $___________________

Elimination Period Accident/Sickness: ☐ 0/7 Days ☐ 7 Days ☐ 0/14 Days ☐ 14 Days ☐ 30 Days ☐ 60 Days ☐ 90 Days

Benefit Period: ☐ 3 Months ☐ 6 Months ☐ 12 Months ☐ 24 Months

Optional Riders:
☐ Return of Premium Benefit Rider (check one option) ☐ 50% ☐ 80%
☐ Hospital Confinement Indemnity Benefits Rider ☐ $125 ☐ $250 ☐ $350 ☐ $500
☐ Critical Illness Benefits Rider (check one option) ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $25,000

Long-Term Disability Insurance

Base Monthly Benefit Amount $___________________ **SIS Monthly Benefit Amount $** _____________

Elimination Period: ☐ 60 Days ☐ 90 Days ☐ 180 Days ☐ 365 Days

Benefit Period: ☐ 2 Years ☐ 5 Years ☐ 10 Years ☐ To Age 67

Optional Riders:
☐ SIS (Social Insurance Supplement) Benefits Rider
Do you have any dependent children age 17 or under? ☐ Yes ☐ No
Are you covered under the Social Security Act? ☐ Yes ☐ No
☐ Return of Premium Benefit Rider (check one option)
☐ 50% ☐ 80%
☐ Hospital Confinement Indemnity Benefits Rider (check one option)
☐ $125 ☐ $250 ☐ $350 ☐ $500
☐ Critical Illness Benefits Rider (check one option)
☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $25,000

☐ Extended Proportionate Disability Benefits Rider
☐ Future Insurability Option (FIO) Rider
☐ Extended Own-Occ. Disability Defin. Amend. Rider
☐ Cost-of-Living Adjustment (COLA) Rider

Business Operating Expense Disability Insurance

Monthly Benefit Amount $___________________

Elimination Period: ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 180 Days ☐ 365 Days

Benefit Period: ☐ 12 Months ☐ 18 Months

Optional Riders: ☐ Accidental Death Rider Benefit Amt. $ ___________
☐ Accidental Death and Dismemberment Rider Benefit Amt. $ ___________

SECTION F PREMIUM COLLECTION

Billing Options:

1. No Cash With App (Effective Date = Issue Date)

☐ BSP

2. Cash With App (Effective Date = Application Date)

Initial Premium Collected $______________ Renewal Premium $______________

☐ BSP (If BSP is selected, collect 2 months of premium.)
☐ Quarterly
☐ Semiannual
☐ Annual

3. Payroll Deduction (only available with Accident Only plan)

Add to Existing PRD – Group Number.. ____________________________

First Deduction Date .... ____________________________

Number of Deductions.. ____________________________

Effective Date .... ____________________________

SECTION G Complete only if Billing Mode is BSP

AUTHORIZATION TO WITHDRAW FUNDS BY MUTUAL OF OMAHA INSURANCE COMPANY ("MUTUAL OF OMAHA")

I authorize Mutual of Omaha to withdraw funds from my account for my initial and/or renewal premiums and understand that the amounts may differ. I also authorize Mutual of Omaha to collect any premium(s) due by bank draft withdrawal. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize you, my financial institution, to pay from my account any checks, drafts or preauthorized electronic fund transfers from my account to Mutual of Omaha. Your rights with each charge will be the same as if personally paid by me. This authorization will be effective until I give you at least three business days' notice to cancel it. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

1. Specify the date the premiums will be withdrawn: ☐ 1st of the Month or ☐ 15th of the Month

2. Attach your check from the account from which premiums will be withdrawn or provide routing and account number.

Routing Number ____________________________________ Account Number ____________________________________

SECTION H PLEASE READ AND SIGN

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

I authorize physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations, MIB (Medical Information Bureau), insurers, employers, consumer reporting agencies and any other organization, institution, or person that has records or knowledge of me or my health to release personal information about me to Mutual of Omaha Insurance Company or its affiliated companies (Mutual).

Personal information includes my health information such as medical history, mental or physical condition, prescription drug records, drug or alcohol use and other information such as finances, occupation, general reputation and insurance claims information. The personal information may include my entire medical record.

The Personal information will be used to determine my eligibility for insurance or to resolve or contest any issues of incomplete, incorrect or misrepresented information on the application that may arise during the processing of my application or in connection with a claim.

I also authorize Mutual to disclose my personal information to the MIB. I understand that my personal information received by the MIB may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits.

If the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the information may be redisclosed without the protection of the federal privacy regulations.

I understand that I may refuse to sign this authorization. I realize if I refuse to sign, the insurance for which I am applying will not be issued.

This authorization will expire 24 months after the date signed. I may revoke this authorization at any time by written notice to ATTN: Individual Underwriting, Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175. This revocation is limited to the extent that Mutual has taken action in reliance on the authorization or the law allows Mutual to contest the issuance of the policy or a claim under the policy. I understand that I will receive a copy of this authorization and that a copy is as valid as the original.

AGREEMENTS AND ACKNOWLEDGEMENTS

1. The undersigned applicant agrees that (a) all answers in this application are true and complete and Mutual of Omaha Insurance Company will rely on these answers to determine insurability, and (b) incorrect or misleading answers may void this application and any policy Issued from its effective date.
2. Applicant acknowledges that Mutual of Omaha Insurance Company may require: medical records, an underwriting assessment, a medical examination, or other information.
3. Applicant agrees that Mutual of Omaha Insurance Company will not issue a policy as a result of this application unless (a) the insurance applicant completes all medical examinations and tests required by Mutual of Omaha Insurance Company, (b) Mutual of Omaha Insurance Company receives any additional information requested for underwriting, and (c) the insurance applicant is, as of the policy application date, determined to be eligible for the exact insurance applied for, or the insurance applicant has subsequently accepted an offer by Mutual of Omaha Insurance Company for coverage other than as applied for, according to the underwriting standards of Mutual of Omaha Insurance Company then in force.
4. Applicant agrees that this application does not provide temporary or interim insurance prior to policy issuance. If the applicant has made an advance premium payment, applicant agrees to the terms and conditions of the Conditional Receipt. Applicant agrees that completing this application or making an advance premium payment is not a guarantee that this application will be approved. If approved, the issued policy will indicate its effective date. Applicant acknowledges that if his or her application is declined, the insurance coverage applied for will not become effective and any advance premium payment submitted with the application will be refunded to applicant, without interest. No insurance coverage will be in effect until Mutual of Omaha Insurance Company (a) issues a policy and (b) receives payment of the full initial premium according to the mode of payment specified in the application.
5. Applicant acknowledges that no producer can (a) waive or change any receipt or policy provision, or (b) agree to issue a policy.

SECTION H	PLEASE READ AND SIGN - continued

I have (a) read and understand the Authorization to Disclose Personal Information and Agreement Section; (b) read and approved the answers as recorded on this application; and (c) received the appropriate Outline/Summary of Coverage.

Signed at: ______________________________ ______________________________
City State Date

______________________________ ______________________________ ______________________________
Signature of Proposed Insured Printed Name of Proposed Insured Date

______________________________ ______________________________ ______________________________
Signature of Payor as shown on bank account Printed Name of Payor Date
(if Billing Mode is BSP and Payor is other than Proposed Insured)

I/We certify that during an interview with the Proposed Insured(s), I/we asked each question exactly as written and recorded the answers provided by the Proposed Insured(s) completely and accurately. . . . . ☐ Yes ☐ No

(If "No," please explain.)______________________________

I conducted said interview in person ☐ Yes ☐ No

(If "No," please explain.)______________________________

______________________________ ______________________________ ______________________________
Signature of Producer Producer's Printed Name Date

______________________________ ______________________________
Office Name Office Address

______________________________ ______________________________ ______________________________
Signature of Producer Producer's Printed Name Date

______________________________ ______________________________
Office Name Office Address

Michigan – Authorization To Disclose Personal Information To Mutual of Omaha Insurance Company

Meanings of Terms

"Medical Persons and Entities" means: all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services.

"Personal Information" means: all health information, such as medical history, mental and physical condition, including the presence of HIV infection, AIDS or ARC, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me and, if my children are proposed insureds, my children also. Personal Information does not include Psychotherapy Notes.

"Psychotherapy Notes" means: notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person's medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.

"Specified Companies" means:

- The group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, United World Life Insurance Company, Companion Life Insurance Company, additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

Authorization to Disclose

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me and, if my children are proposed insureds, about my children to Mutual of Omaha Insurance Company.

Purposes

The Personal Information will be used to determine my or my children's eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application which may arise during the processing of my application or in connection with claims for insurance benefits.

Potential for Redisclosure

If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.

Failure to Sign

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.

Expiration and Revocation

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to:

ATTN: Individual Underwriting
Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175-0001

I realize that my right to revoke this authorization is limited to the extent that Mutual of Omaha Insurance Company has taken action in reliance on the authorization or the law allows Mutual of Omaha Insurance Company to contest the issuance of the policy or a claim under the policy.

Copy

I understand that I will receive a copy of the signed authorization. A copy of this authorization is as effective as the original.

Names and Signatures

Name(s) used for medical records (if different than the name(s) below): ______________________________

______________________	______________________	______________________
Printed Name of Proposed Insured	Spouse's Printed Name (If Proposed Insured)	If children are to be insured, their printed names
______________________	______________________	______________________
Signature of Proposed Insured	Signature of Spouse (If Proposed Insured)	Signature of Parent or Guardian (If Proposed Insured is a Minor)
______________________	______________________	______________________
Date	Date	Date

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

Authorization to Receive Information From and Disclose Information to the MIB Group, Inc. ("MIB")

Meanings of Terms

"MIB Group, Inc. (MIB)" means: a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

"Personal Information" means: all health information, such as medical history, mental and physical condition, including the presence of HIV infection, AIDS or ARC, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me and, if my children are proposed insureds, my children also.

"Specified Companies" means:

- The group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, Companion Life Insurance Company, additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

Authorization to Receive and Disclose

To the MIB:

I authorize you to disclose Personal Information about me (the undersigned) or my children to the Specified Companies and their reinsurers. You are not authorized to disclose information about me to a consumer reporting agency. Information received will assist in verifying the accuracy of the information I have provided in my application(s) for insurance with one or more of the Specified Companies.

I also authorize the Specified Companies and their reinsurers to disclose Personal Information about me or my children to the MIB. I understand that the Personal Information received by the MIB may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to:

Attn: Individual Underwriting
Mutual of Omaha
Mutual of Omaha Plaza
Omaha, NE 68175-0001

I also understand that any revocation of this authorization will not affect any use or disclosure of Personal Information that occurred prior to the receipt of my revocation.

I have been advised that I, or my authorized representative, am entitled to receive a copy of this authorization. A copy of this authorization is as effective as the original.

Name(s) used for medical records (if different than the name(s) below): ______________________________

____

____

______________________________ Signature of Proposed Insured	______________________ Date
______________________________ Signature of Spouse (If Proposed Insured)	______________________ Date
______________________________ Signature of Parent or Guardian (If Proposed Insured is a Minor)	______________________ Date

Agent/Producer Statement

1 Do you have any reason to believe the policy applied for has replaced or will replace any existing disability income insurance? (If "Yes," fulfill all state requirements.) .... ☐ Yes ☐ No

2 Has a medical examination of the Proposed Insured been scheduled? .... ☐ Yes ☐ No

If "Yes," when? ____________________ By ____________________

3 Has the client profile interview been completed? .... ☐ Yes ☐ No

If "No," the client profile interview has been scheduled for __________ (Date) and __________ (Time (Please circle –Eastern, Central, Mountain or Pacific))

4 Did you give the Notice of Information Practices to the Proposed Insured? .... ☐ Yes ☐ No

Date ____________ (Mo. Day Yr.) ____________________ Agent/Producer's Signature ____________________ Agent/Producer's Signature

Agent/Producer Information:

Agent/Producer Name ____________________ Agent/Producer Social Security Number ____________

Comm. % Share ____________________ Agent/Producer Phone Number (______) ____________ (Area Code)

Agent/Producer E-mail Address ____

Agent/Producer's Stamp ____________________ Agent/Producer's License/ID Number ____________

Agent/Producer Name ____________________ Agent/Producer Social Security Number ____________

Comm. % Share ____________________ Agent/Producer Phone Number (______) ____________ (Area Code)

Agent/Producer E-mail Address ____

Agent/Producer's Stamp ____________________ Agent/Producer's License/ID Number ____________

Mutual of Omaha Insurance Company
Notice of Information Practices

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. Upon request, you have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge you to review your application carefully to be sure the answers are correct and complete.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: MUTUAL OF OMAHA INSURANCE COMPANY, DIRECTOR OF INDIVIDUAL UNDERWRITING, MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175.

M26977

Mutual of Omaha Insurance Company
MIB Group, Inc. Pre-Notice

Information regarding your insurability will be treated as confidential. Mutual of Omaha Insurance Company or its reinsurers may make a brief report to the MIB Group, Inc. (MIB), a nonprofit membership organization of insurance companies which operates an information exchange for its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply the information in its file to that company.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734

In compliance with applicable law, Mutual of Omaha Insurance Company, or its reinsurers, may also release information in its file, including information given in your application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted. **Information for consumers about MIB may be obtained on its website at www.mib.com.**

M26978_0809

Remove Notices and Give to Proposed Insured

Conditional Receipt

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175

☐ **Initial Premium paid by check**
Money was collected - Received $____________________ from ______________________ paid with an insurance application on ____, dated ____________________
(person(s) proposed for insurance)

(ALL CHECKS FOR PREMIUMS MUST BE MADE PAYABLE TO MUTUAL OF OMAHA INSURANCE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.)

This Conditional Receipt will provide limited insurance coverage for each person proposed for insurance, subject to all of the provisions of the policy(ies) applied for, as of the application date, but only if all of the following conditions have been completely met:

1. Written application.
2. Payment of the full initial premium.
3. Completion by the Proposed Insured of all examinations and tests (medical, paramedical, laboratory) required by Mutual of Omaha Insurance Company.
4. Receipt by Mutual of Omaha Insurance Company of any additional information (such as an Attending Physician's Statement) requested for underwriting.
5. Satisfying Mutual of Omaha Insurance Company underwriting standards.

If (a) any of the above conditions are not exactly met, or (b) the above conditions are exactly met but the person proposed for insurance dies by suicide, whether sane or insane (except in Colorado and Missouri), or (c) the application is not accepted by Mutual of Omaha, no insurance coverage will be provided under this Conditional Receipt, and Mutual of Omaha's only liability will be to notify the applicant in writing and return the premium paid.

For each person proposed for insurance, the maximum benefit payable under this Conditional Receipt will be the lesser of: (a) the total benefit payable under all pending applications with Mutual of Omaha relating to the person proposed for insurance, or (b) $50,000. This Receipt provides no coverage for policy Riders.

Regardless of any other provision of this Conditional Receipt, any coverage that becomes effective under this Conditional Receipt will terminate on the earliest of the following: (a) the effective date of a policy issued as a result of this application; (b) the date Mutual of Omaha mails notice that the coverage applied for will not be issued and refunds any premium paid; or (c) 60 days following the date of the application. Either Mutual of Omaha or the person proposed for insurance may terminate this Conditional Receipt as to such person by providing written notice to the other party.

If you are eligible, the effective date of the insurance will be the date of the application, or the date the number of applications received from members of your group meets the minimum participation requirements, whichever date is later. **If you are not eligible, no insurance or temporary or interim insurance of any kind will be in effect.**

In no event will benefits be paid for the same loss under both this Conditional Receipt and any insurance policy issued from the application.

No producer is authorized to alter the terms of this Receipt, waive any representations, or pass on insurability.

I understand and agree to the terms, conditions and limitations of this Conditional Receipt and the Agreement section of the application. These have been fully explained to me by the Producer.

Date: ____ Signed at: ____
City State

____
Signature of Proposed Insured

____ ____
Signature of Producer Signature of Producer

Conditional Receipt

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175

☐ **Initial Premium paid by check**
Money was collected - Received $____________________ from ______________________ paid with an insurance application on ____, dated ____________________
(person(s) proposed for insurance)

(ALL CHECKS FOR PREMIUMS MUST BE MADE PAYABLE TO MUTUAL OF OMAHA INSURANCE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.)

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1. Written application.
2. Payment of the full initial premium.
3. Completion by the Proposed Insured of all examinations and tests (medical, paramedical, laboratory) required by Mutual of Omaha Insurance Company.
4. Receipt by Mutual of Omaha Insurance Company of any additional information (such as an Attending Physician's Statement) requested for underwriting.
5. Satisfying Mutual of Omaha Insurance Company underwriting standards.

If (a) any of the above conditions are not exactly met, or (b) the above conditions are exactly met but the person proposed for insurance dies by suicide, whether sane or insane (except in Colorado and Missouri), or (c) the application is not accepted by Mutual of Omaha, no insurance coverage will be provided under this Conditional Receipt, and Mutual of Omaha's only liability will be to notify the applicant in writing and return the premium paid.

For each person proposed for insurance, the maximum benefit payable under this Conditional Receipt will be the lesser of: (a) the total benefit payable under all pending applications with Mutual of Omaha relating to the person proposed for insurance, or (b) $50,000. This Receipt provides no coverage for policy Riders.

Regardless of any other provision of this Conditional Receipt, any coverage that becomes effective under this Conditional Receipt will terminate on the earliest of the following: (a) the effective date of a policy issued as a result of this application; (b) the date Mutual of Omaha mails notice that the coverage applied for will not be issued and refunds any premium paid; or (c) 60 days following the date of the application. Either Mutual of Omaha or the person proposed for insurance may terminate this Conditional Receipt as to such person by providing written notice to the other party.

If you are eligible, the effective date of the insurance will be the date of the application, or the date the number of applications received from members of your group meets the minimum participation requirements, whichever date is later. **If you are not eligible, no insurance or temporary or interim insurance of any kind will be in effect.**

In no event will benefits be paid for the same loss under both this Conditional Receipt and any insurance policy issued from the application.

No producer is authorized to alter the terms of this Receipt, waive any representations, or pass on insurability.

I understand and agree to the terms, conditions and limitations of this Conditional Receipt and the Agreement section of the application. These have been fully explained to me by the Producer.

Date: ____ Signed at: ____
City State

____
Signature of Proposed Insured

____ ____
Signature of Producer Signature of Producer

Important Health Information

Michigan Community Public Health Agency
HP-143
Authority: P.A. 368/1978
(Revised 6/96)

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Human Immunodeficiency Virus (HIV) Test (AIDS Virus) Information Booklet with Consent Form

Q: What is an HIV Test?

A: Human Immunodeficiency Virus (HIV) is the virus that causes Acquired Immunodeficiency Syndrome (AIDS).

Laboratory tests tell whether you have been infected with HIV. A test is not considered positive unless a different, backup test is done and also reads positive. These tests are conducted on a single sample of your blood, or on an oral sample from your mouth. Test results may, on rare occasions, be inconclusive, and this possibility should be discussed with your health professional.

Q: Will the HIV test tell me if I have AIDS?

A: No. A positive test means you have been exposed to the virus and that you have become infected. While some people infected with the virus have gone on to develop AIDS, others have not yet developed AIDS. Healthy lifestyle and behavior changes, improved diet and early medical treatment may help you delay, or avoid, the development of AIDS.

A positive test will not tell you if you have AIDS, whether you will develop AIDS or how long you've been infected. The period from time of infection to the development of AIDS may be eleven years or more.

Q: How long after exposure does it take to tell if I am infected?

A: Most people will test positive within three months to six months after exposure. The average time is 45 days. However, a few people have taken up to one year to test positive.

Q: How does a person become infected with HIV?

A: The virus is most commonly spread through sexual contact (vaginal, anal, or oral sex) and by sharing of needles or works to shoot injectable drugs. An infected mother may infect her baby during pregnancy, at the time of birth, or while breast feeding. Very rarely, contact with blood through open cuts or wounds, or splashes to the eyes, may also spread the virus. **You cannot get infected with the virus by donating or giving blood, or through casual contact.**

Q: Do I have to have this test?

A: Generally, whether you are tested is your decision. In Michigan, testing is required if you are a potential organ, semen, tissue, or blood donor; a military recruit; an immigrant; or if you have been charged and bound over, or convicted of certain crimes in a court of law. In addition, some health care facilities may have an admission requirement that you consent to be tested if a health care worker is accidentally exposed to your blood during your stay in their facility.

An insurance company has the right to request that you take an HIV test if you apply for new health or life insurance. If you refuse or if you test positive, as with any other potentially serious health condition, you will probably be turned down for this new insurance.

Q: Who should consider having the HIV test?

A: The Michigan Community Public Health Agency recommends that HIV testing be considered by anyone who meets any of the following:

- People who may have a sexually-transmitted disease (venereal disease).
- People who have shared needles or who have a history of drug abuse.
- Men who have had sex with other men.
- Men or women who have had unprotected sex with anyone who is not known to have tested HIV negative. (Unprotected sex means there has been an exchange of semen and/or vaginal secretions between the partners.)
- People who have had more than one sex partner.
- People who have had sex with prostitutes (male or female).
- People who received blood products or blood transfusions between 1978 and 1985.
- People who exchange sex for drugs or money.
- Women with known risks, who are pregnant or who are considering pregnancy.
- People who are infected with tuberculosis.

- People who have had exposure to the blood of someone who may be infected.
- People who have had sex with any person from the above list, particularly with injecting drug users.

Q: Where can I have the test done without my name being used?

A: All local health departments and other testing centers designated by the Michigan Community Public Health Agency will provide the option to you to be tested with your name (confidential testing) or without your name (anonymous testing). Any person giving you this test is required by law to keep your test results confidential, with a few exceptions specified by law. If you request testing without your name, these facilities have trained counselors who will counsel you on an anonymous basis.

If anonymous testing is done and you have a positive test, you need to know that health care and treatment are not provided on an anonymous basis. To receive a copy of your test results, a name will be required and retesting will be recommended.

Q: Who will know the results of my test?

A: Once again, any person giving you this test is required by law to keep your test results confidential. Even the courts must follow specific rules before they can require disclosure through a court order. A subpoena is not sufficient to require disclosure. You will be asked to sign a separate release form. If this information needs to be released beyond the requirements of the law, you will be asked to sign a separate release form.

In Michigan, positive test results are reportable to the health department. The health department will maintain your confidentiality and use this information to understand the extent of infection in Michigan's communities. This information may also be used by your health provider or local health department as needed to properly diagnose and care for you and protect your health, to assist you in notifying your sexual or needle-sharing partners, and to prevent spread of the virus. The test results, if positive, will also be given to a potential spouse if you are planning to get married. If you are a health care worker (HCW), you should be aware of state guidelines regarding infected HCWs.

If you are tested in a physician's private practice office, or in the office of a physician affiliated with or under contract with a Health Maintenance Organization, you may request that your name, address, and phone number not be included in the HIV positive report to local public health. It is against the law in Michigan for local public health departments to keep lists of names of infected people.

Michigan law now requires that, if you are infected, your physician or the local health officer must warn (notify) all of your known sexual or needle-sharing partners of the fact that they have been exposed. In doing this, they are required to keep your identity confidential.

Q: Are there any risks involved in having the test done?

A: There are virtually no medical risks in drawing a small sample of blood. Only sterile needles and syringes are used for this purpose. Once the needle or syringe is used, it is safely thrown away, or properly sterilized. If an oral sample is used for the test, a specially-treated pad is placed between the lower cheek and gum and held for two minutes. This causes no risk or pain to the patient.

Before you are tested, you should carefully think about to whom you would tell the results, and what emotional support system are available to you. The Michigan Civil Rights Commission has ruled that AIDS, HIV infection, and the suspicion of AIDS or HIV infection are considered handicapping conditions. Therefore, people are not to be discriminated against, and have all the rights of a handicapped person as defined under the Handicappers' Civil Rights Act of 1974. The federal laws make similar rulings through the federal Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. The Americans with Disabilities Act of 1990 strictly forbids discrimination against persons with HIV or AIDS.

Q: What will happen to the consent form after I sign it?

A: Procedures for filing the consent form will vary from facility to facility. Please ask your health professional if you would like to know what their confidentiality procedure is.

Q: Can I change my mind after I sign the consent form?

A: Yes, you can change your mind at any time before the laboratory performs the test. If you change your mind, you will have to provide a written request to the person or organization providing you with this information booklet that the test not be done.

Q: How will this test help me?

A: <u>If you are tested, you most likely will be required to appear in person to get your test results.</u> Whether your results are positive or negative, your overall health may be helped from discussions with your health professional.

If you test negative, the test indicates either that you are not infected, or possibly, that you were infected very recently (within the past 3-6 months). You can learn through counseling how to protect yourself from infection in the future. If you have recently practiced risky behavior, you may want to be retested, especially if you have one or more of the risks listed on pages 1 and 2.

If you test positive, the test indicates that you have been infected with HIV. You can still take action to benefit your health and the health of others. This includes maintaining a good state of physical and mental health. By doing so, you may delay the development of AIDS. It is suggested that you:

- Maintain good nutrition, exercise and get adequate rest;
- Receive emotional support, and work on managing stress;
- Eliminate recreational drugs, (or at least reduce) alcohol, and smoking;
- Avoid getting sexually-transmitted diseases (use latex condoms);
- Stop injecting drugs and sharing equipment if you do so now. The next best practice would be to not share needles or works. At the very least, you should learn to clean your needles or works.
- Receive all recommended vaccines. Discuss with your physician which vaccines are recommended and which should be avoided.
- Inform all known sexual or needle-sharing partners.

Drugs are now available for treatment of persons infected with HIV even if symptoms are not present. Knowledge of whether one is infected may be important because early treatment is beneficial to many people with HIV.

To Reduce the Chance of Infecting Others, the following precautions should be taken if you are HIV-infected:

- Don't have sex that exposes others to your semen, vaginal secretions or blood.
- If you are going to have sex, always inform your partner before having sex that you are infected, and use a latex condom.
- Seek counseling regarding becoming pregnant or fathering a child.
- Do not donate blood or organs (change designation on driver's license).
- Seek treatment for drug abuse; do not share needles or works; at the very least, learn to clean needles and works.
- If you are pregnant and planning to continue that pregnancy, discuss with your physician treatments that may protect your baby.

Q: Whom should I tell if I am HIV-positive?

A: If you test positive, you need to know that this infection is not passed to another person through casual contact. Michigan law requires that you must notify any new sexual partner prior to having sex with them. Past sexual and needle-sharing partners are to be notified so that they can also be counseled and offered testing. If requested, your local health department will provide you assistance in notifying partners.

Inform all health care providers, both medical and dental, who are providing you treatment, about your HIV infection. This will help them care for you.

The law prohibits health care providers from refusing to treat you based upon your HIV infection.

Recent studies have shown that the administration of the drug "zidovudine" (AZT) to HIV-infected women during their pregnancy will help reduce the transmission of HIV to their infants. This drug may reduce the risk of transmission from mother to newborn by about two thirds. If you know you are infected with HIV and pregnant, you should consult with your health care provider about taking this drug.

Finally, be careful about discussing your HIV status with others. Some people may not understand the nature of the infection or how it is actually spread. This may lead to misunderstanding and create problems for you with friends, co-workers, or others.

Q: What if I have more questions?

A: Please ask the health professional who gave you this booklet. Your health professional will have the answers to your questions or will get the answers for you.

You should feel free to call the statewide AIDS information hotline (1-800-872-AIDS; Spanish 1-800-862-SIDA; TDD 1-800-332-0849) or your local health department at anytime, if you have questions or need help.

Consent Form For The Human Immunodeficiency Virus (HIV) Test

I have been informed that my blood or oral sample from my mouth will be tested for the Human Immunodeficiency Virus (HIV), the virus that causes AIDS.

I acknowledge that I have been given an explanation of the test, including its uses, benefits, limitations, and the meaning of test results.

I have been informed that the HIV test results are confidential and shall not be released without my written permission, except to ____* and as permitted under state law.

I understand that I have a right to have this test be done without the use of my name. If my private physician does not provide anonymous testing, I understand I may obtain anonymous testing at a Michigan Community Public Health Agency-approved HIV counseling and testing site.

I understand that I have the right to withdraw my consent for the test at any time before the test is complete.

I acknowledge that I have been given a copy of the booklet *Important Health Information*. I have been given the opportunity to ask questions concerning the test for HIV, and I acknowledge that my questions have been answered to my satisfaction.

By my signature below, I consent to be tested for HIV.

______________________________________ ______________________
Patient/Parent/Guardian Signature Date

______________________________________ ______________________
Witness Date

AT THIS TIME, I DO NOT WANT TO BE TESTED FOR THE HUMAN IMMUNODEFICIENCY VIRUS

______________________________________ ______________________
Patient/Parent/Guardian Signature Date

______________________________________ ______________________
Witness Date

***Please write in the physician and/or health facility name who will receive the HIV test results.**

Consent Form For The Human Immunodeficiency Virus (HIV) Test

I have been informed that my blood or oral sample from my mouth will be tested for the Human Immunodeficiency Virus (HIV), the virus that causes AIDS.

I acknowledge that I have been given an explanation of the test, including its uses, benefits, limitations, and the meaning of test results.

I have been informed that the HIV test results are confidential and shall not be released without my written permission, except to ____* and as permitted under state law.

I understand that I have a right to have this test be done without the use of my name. If my private physician does not provide anonymous testing, I understand I may obtain anonymous testing at a Michigan Community Public Health Agency-approved HIV counseling and testing site.

I understand that I have the right to withdraw my consent for the test at any time before the test is complete.

I acknowledge that I have been given a copy of the booklet *Important Health Information*. I have been given the opportunity to ask questions concerning the test for HIV, and I acknowledge that my questions have been answered to my satisfaction.

By my signature below, I consent to be tested for HIV.

Patient/Parent/Guardian Signature	Date
Witness	Date

AT THIS TIME, I DO NOT WANT TO BE TESTED FOR THE HUMAN IMMUNODEFICIENCY VIRUS

Patient/Parent/Guardian Signature	Date
Witness	Date

***Please write in the physician and/or health facility name who will receive the HIV test results.**

Original – FOR CLIENT

M20440_1002

Long-Term Disability Income Insurance Coverage – Outline of Coverage

For Policy Form D81-20949 and D81-20950

Read Your Policy Carefully

This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Disability Income Insurance Coverage

Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

Total Disability Benefits

If you are Totally Disabled because of a Sickness or Injury, we will pay the Total Disability Monthly Benefit. Total Disability benefits begin after the Elimination Period has been satisfied. Benefits are payable while you remain Totally Disabled for as long as the Benefit Period.

Proportionate Disability Benefits

If you are Proportionately Disabled because of Sickness or Injury and incur a 20% or greater Loss of Monthly Income, we will pay a percentage of your Total Disability Monthly Benefit that is proportionate to your lost income.

Presumptive Total Disability Benefits

We will automatically pay Total Disability Benefits under your policy and any Social Insurance Supplement Benefits Rider for the full length of the Benefit Period upon proof of your presumptive Total Disability. Benefits are payable even if you return to work at any occupation. The Elimination Period will be waived. Regular Medical Care will not be required. You will be presumed to be permanently Totally Disabled if Sickness or Injury results in the complete and irrecoverable loss of your:

(a) speech;

(b) hearing in both ears;

(c) sight in both eyes; or

(d) the use of both hands, both feet or one hand and one foot.

Transplant Donor Benefits

If you become Totally Disabled or Proportionately Disabled as the result of a transplant of part of your body to the body of another person, we will pay benefits under your policy and any Social Insurance Supplement Benefits Rider on the same basis as any other Sickness.

Terminal Illness Benefit

If you are diagnosed with a Terminal Illness, you can elect to receive an accelerated payment of the remaining Total Disability Monthly Benefits due in a lump sum amount. This Terminal Illness Benefit may accelerate up to 12 months of the current benefits payable under your policy and any Social Insurance Supplement Benefits Rider.

Survivor Benefit

Upon your death, we will pay a Survivor Benefit to your designated Beneficiary, if Total or Proportionate Disability benefits were payable; and the Benefit Period was not exhausted.

Rehabilitation Benefit

While you are receiving Total Disability or Proportionate Disability benefits, we may pay for a vocational rehabilitation program.

Guaranteed Renewable to Age 67, Conditionally Renewable Thereafter to Age 75

You are guaranteed the right to continue your coverage until Age 67. During that time, we cannot cancel your policy as long as you pay the required premium when it is due. After Age 67, you may continue your coverage to Age 75 provided you maintain Full-Time Employment and pay the necessary premium when due.

Premium Changes

Your policy's premium may change before Age 67, but only if the same change is made to all policies of this form issued to persons of the same Class. After Age 67, the premium will increase every year because the premium rate is then based upon your attained age. The premium may also change for other reasons after Age 67, but only if we make the same change on a Class basis. We will give you at least 45 days advance written notice before any premium change. In no event will the premium increase during the first 12 months following the Policy Date.

Exclusions and Limitations

Benefits are not payable for:

(a) loss that begins while this policy is not in force;

(b) loss resulting from an act of declared or undeclared war;

(c) loss sustained while serving in the armed forces (upon notice to us of entry into the armed forces, the unearned portion of the premium will be refunded);

(d) loss caused by intentionally self-inflicted injury (while sane in Colorado);

(e) loss resulting from commission or attempted commission of a felony;

(f) loss caused by suicide or attempted suicide, while sane or insane (sane only in Colorado and Missouri); or

(g) loss resulting from your being legally intoxicated or under the influence of an illegal substance or a narcotic (except for narcotics given on the advice of and taken as prescribed by a Physician).

Pregnancy

Benefits are not payable for loss due to Normal Childbirth, Normal Pregnancy or voluntarily induced abortion. We will pay benefits for Complications of Pregnancy on the same basis as any other Sickness.

Substance Abuse Limitation

Benefits payable for Substance Abuse are limited to a lifetime maximum of 24 months.

Mental or Nervous Disorder Limitation

Benefits payable for Mental or Nervous Disorders are limited to a lifetime maximum of 24 months.

Benefits Reduction When Association Group Membership or Self-Employment Ends

(Policy Form D81-20950 Only)

This policy form was issued to you because you are self-employed or a member of a franchise/ association group. If your franchise/association membership ends, the organization ceases to endorse this product, or you stop being self-employed, you may continue this coverage. Premiums will not increase as a result of this change. However, all benefits payable for loss beginning after such time will be reduced by 15%.

MUTUAL OF OMAHA INSURANCE COMPANY
Mutual of Omaha Plaza, Omaha, NE 68175, 402-342-7600

SHORT-TERM DISABILITY INCOME INSURANCE – OUTLINE OF COVERAGE

For Policy Form D82-20898 and D82-20899

READ YOUR POLICY CAREFULLY

This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

DISABILITY INCOME INSURANCE COVERAGE

Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

TOTAL DISABILITY BENEFITS

If you are Totally Disabled because of a Sickness or Injury, we will pay the Total Disability Monthly Benefit. Total Disability benefits begin after the Elimination Period has been satisfied. Benefits are payable while you remain Totally Disabled for as long as the Benefit Period.

PARTIAL DISABILITY BENEFITS

If you are partially disabled because of a Sickness or Injury, we will pay 50% of the Total Disability Monthly Benefit. Partial Disability benefits begin after the Elimination Period has been satisfied. Benefits are payable while you remain Partially Disabled for the lesser of six months or the balance of the Benefit Period.

PRESUMPTIVE TOTAL DISABILITY BENEFITS

We will automatically pay Total Disability Benefits for the full length of the Benefit Period upon proof of your presumptive Total Disability. Benefits are payable even if you return to work at any occupation. The Elimination Period will be waived. Regular Medical Care will not be required. You will be presumed to be permanently Totally Disabled if Sickness or Injury results in the complete and irrecoverable loss of your:

(a) speech;
(b) hearing in both ears;
(c) sight in both eyes; or
(d) the use of both hands, both feet or one hand and one foot.

TRANSPLANT DONOR BENEFITS

If you become Totally Disabled or Partially Disabled as the result of a transplant of part of your body to the body of another person, we will pay benefits on the same basis as any other Sickness.

TERMINAL ILLNESS BENEFIT

If you are diagnosed with a Terminal Illness, you can elect to receive an accelerated payment of the remaining Total Disability Monthly Benefits due in a lump sum amount. This Terminal Illness Benefit may accelerate up to 12 months of the current benefits payable under your policy.

SURVIVOR BENEFIT

Upon your death, we will pay a survivor benefit to your designated Beneficiary, if Total or Proportionate Disability benefits were payable; and the Benefit Period was not exhausted.

Rehabilitation Benefit

While you are receiving Total Disability or Partial Disability benefits, we may pay for a vocational rehabilitation program.

Guaranteed Renewable to Age 67, Conditionally Renewable Thereafter to Age 75

You are guaranteed the right to continue your coverage until Age 67. During that time, we cannot cancel your policy as long as you pay the required premium when it is due. After Age 67, you may continue your coverage to Age 75 provided you maintain Full-Time Employment and pay the necessary premium when due.

Premium Changes

Your policy's premium may change before Age 67, but only if the same change is made to all policies of this form issued to persons of the same Class. After Age 67, the premium will increase every year because the premium rate is then based upon your attained age. The premium may also change for other reasons after Age 67, but only if we make the same change on a Class basis. We will give you at least 45 days advance written notice before any premium change. In no event will the premium increase during the first 12 months following the Policy Date.

Exclusions and Limitations

We will not pay benefits for:

(a) loss that begins while this policy is not in force;

(b) loss resulting from an act of declared or undeclared war;

(c) loss sustained while serving in the armed forces (upon notice to us of entry into the armed forces, the unearned portion of the premium will be refunded);

(d) loss caused by intentionally self-inflicted injury (while sane in Colorado);

(e) loss resulting from commission or attempted commission of a felony;

(f) loss caused by suicide or attempted suicide, while sane or insane (sane only in Colorado and Missouri);

(g) loss resulting from your being legally intoxicated or under the influence of an illegal substance or a narcotic (except for narcotics given on the advice of and taken as prescribed by a Physician);

(h) loss resulting from substance abuse; or

(i) loss resulting from mental or nervous disorders.

Pregnancy

Benefits are not payable for loss due to Normal Childbirth, Normal Pregnancy or voluntarily induced abortion. We will pay benefits for Complications of Pregnancy on the same basis as any other Sickness.

Benefit Reduction When Association Group Membership or Self-Employment Ends

(Policy Form D82-20899 Only)

This policy form was issued to you because you are self-employed or a member of a franchise/association group. If your franchise/association membership ends, the organization ceases to endorse this product, or you stop being self-employed, you may continue this coverage. Premiums will not increase as a result of this change. However, all benefits payable for loss beginning after such time will be reduced by 15%.

Workers' Compensation Limitation

Benefits payable for loss for which benefits are provided under any state or federal workers' compensation, employer's liability, or occupational disease law will be reduced by 50%.

Mutual of Omaha Insurance Company

Mutual of Omaha Plaza, Omaha, NE 68175, 402-342-7600

Accident-Only Short-Term Disability Income Insurance Coverage – Outline of Coverage

This Policy Covers Accidents Only
It Does Not Pay Benefits For Loss Resulting From Sickness

For Policy Form D83-20900 and D83-20901

Read Your Policy Carefully

This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Accident Disability Income Insurance Coverage

Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident ONLY, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

Total Disability Benefits

If you are Totally Disabled because of an injury, we will pay the Total Disability Monthly Benefit. Total Disability benefits begin after the Elimination Period has been satisfied. Benefits are payable while you remain Totally Disabled for as long as the Benefit Period.

Partial Disability Benefits

If you are Partially Disabled because of an Injury, we will pay 50% of the Total Disability Monthly Benefit. Partial Disability benefits begin after the Elimination Period has been satisfied. Benefits are payable while you remain Partially Disabled for the lesser of six months or the balance of the Benefit Period.

Presumptive Total Disability Benefits

We will automatically pay Total Disability Benefits for the full length of the Benefit Period upon proof of your presumptive Total Disability. Benefits are payable even if you return to work at any occupation. The Elimination Period will be waived. Regular Medical Care will not be required. You will be presumed to be permanently Totally Disabled if an Injury results in the complete and irrecoverable loss of your:

(a) speech;
(b) hearing in both ears;
(c) sight in both eyes; or
(d) the use of both hands, both feet or one hand and one foot.

Survivor Benefit

Upon your death, we will pay a survivor benefit to your designated Beneficiary, if Total or Proportionate Disability benefits were payable; and the Benefit Period was not exhausted.

Guaranteed Renewable to Age 67

You are guaranteed the right to continue your coverage until Age 67. During that time, we cannot cancel your policy as long as you pay the required premium when it is due.

Premium Changes

Your policy's premium may change, but only if the same change is made to all policies of this form issued to persons of the same Class. We will give you at least 45 days advance written notice before any premium change. In no event will the premium increase during the first 12 months following the Policy Date.

Exclusions

We will not pay benefits for:

(a) loss that begins while this policy is not in force;

(b) loss resulting from an act of declared or undeclared war;

(c) loss sustained while serving in the armed forces (upon notice to us of entry into the armed forces, the unearned portion of the premium will be refunded);

(d) loss caused by intentionally self-inflicted injury (while sane in Colorado);

(e) loss resulting from commission or attempted commission of a felony;

(f) loss caused by suicide or attempted suicide, while sane or insane (sane only in Colorado and Missouri);

(g) loss resulting from your being legally intoxicated or under the influence of an illegal substance or a narcotic (except for narcotics given on the advice of and taken as prescribed by a Physician); or

(h) loss resulting directly or indirectly from disease or bodily infirmity;

Benefits Reduction When Association Group Membership or Self-Employment Ends

(Policy Form D83-20901 Only)

This policy form was issued to you because you are self-employed or a member of a franchise/association group. If your franchise/association membership ends, the organization ceases to endorse this product, or you stop being self-employed, you may continue this coverage. Premiums will not increase as a result of this change. However, all benefits payable for loss beginning after such time will be reduced by 15%.

Workers' Compensation Limitation

Benefits payable for loss for which benefits are provided under any state or federal workers' compensation, employer's liability, or occupational disease law will be reduced by 50%.

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza, Omaha, NE 68175, 402-342-7600

Business Operating Expense Summary of Coverage

For Policy Form 150BE

This coverage provides benefits for the operating expense of a business or a practice when the owner/Insured is completely unable to engage in his or her occupation (in CT, IA & VA, unable to engage in substantial and material duties of his or her occupation) as a result of covered illness or injury, receives no earnings for performing other work or service and receives medical treatment. Benefits of your plan are as indicated in your policy.

Renewal Agreement

We will renew your policy each time you send us the premium until you reach age 65. However, the policy will terminate when you retire, sell your business, or discontinue your business or the practice of your business or profession.

Premium Change

Your premium cannot be changed unless we make the same change on all policies of this form (and series in AL) issued to persons of the same classification in your state. In SC, you will receive at least 31 days' notice of a premium change.

Accidental Death Benefit (Not available in SC)

An amount equal to the total annualized premium of the policy and all riders in effect on the date of a covered accident, multiplied by the number of full years the policy has been in force, will be paid when such injury results in the Insured's death within 90 days (180 days in UT) after the date of the accident. This benefit is paid in addition to any other benefit under the policy. If there is a change of Insured, the Policy Date for this provision will be the date such change takes effect (not applicable in TN). (In TN, the minimum benefit is $1,000).

In VA, benefit is payable if injuries you receive while the policy is in force cause your death within: (a) 90 days of the accident or (b) 12 months of the accident if, as a result of the accident, you suffered continuous total disability that began within 30 days of the accident. The benefit is an amount equal to the total annualized premium of the policy and all riders in effect on the date of the accident, multiplied by the number of full years the policy has been in force. It is payable in addition to any other benefit. The minimum benefit is $1,000.00. If there is a change of Insured, the Policy Date, for this provision will be the date such change takes effect. Benefits are not payable for loss caused by suicide while sane or insane, an act of declared or undeclared war or sustained while in an armed service.

Tax Deductible

Your Business Operating Expense Policy has been designed to meet the requirements of Internal Revenue Service rulings which allow certain business professionals who are sole proprietors, partners and stockholders/employees of a business to use premiums for the policy as direct business expense for tax deduction. This is based on current tax code.

Preexisting Sickness or Injury (Not applicable in PA)

Means a sickness or injury which first makes itself known or is medically treated before the Policy Date and which must be disclosed as requested on the application. In MA, a sickness or injury makes itself known when the symptoms are clear enough to cause a prudent person to seek medical attention. Benefits are payable for such preexisting sickness or injuries made known to us on the application and not excluded from coverage. Benefits for such conditions shown on the policy Schedule will be payable only for such loss which starts after the policy has been in force at least 12 months. In AR, a sickness or injury for which medical advice or treatment was recommended by or received from a physician within five years from the Policy Date and which must be disclosed as requested on the application. Benefits are payable for such preexisting sickness or injuries made known to us on the application and not excluded from coverage. Benefits for such conditions shown on the policy Schedule will be payable only for such loss which starts after the policy has been in force at least 12 months.

In CT, IA & WA, benefits will not be payable for loss caused by any condition, which makes itself known during the five-year period prior to the date the person suffering the loss became insured. A condition will be considered to have made itself known when medical care or treatment has been given, or there exist symptoms which could cause an ordinarily prudent person to seek diagnosis, care or treatment. In CT, this provision does not affect our rights with respect to any material misrepresentations contained in the application.

In VA, Subject to the Time Limit on Certain Defenses provision, benefits are not payable under the policy for loss caused by any condition which makes itself known during the two-year period prior to the Policy Date. A condition will be considered to have made itself known when: (1) medical advice or treatment has been received from a physician; or (2) there exist symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment.

Exceptions

Benefits are not payable for: (a) loss beginning while the policy is not in force; (b) loss resulting from suicide while sane or insane (in MO, while sane only); (c) loss resulting from air

travel unless sustained while a passenger (not as a pilot or member of the crew) for transportation only; (d) loss caused by an act of declared or undeclared war; (e) loss sustained while in an armed service (upon notice to the Company of entry into such service, the pro rata premium will be refunded); (f) normal childbirth, normal pregnancy or voluntarily induced abortion; or in MN childbirth or pregnancy; (g) in AR, loss resulting from certain pregnancy related conditions; (h) in KS, NH, PR and WA, childbirth, pregnancy or complications resulting therefrom; (l) in MN, alcoholism, drug addition or drug dependence.

In CO, FL, ID, MN, NC & UT, benefits are payable for complications of pregnancy on the same basis as any other covered sickness.

In MT & UT, subject to all policy provisions and limitations, maternity is payable on the same basis as any other sickness.

We will not be liable for any loss that results from being under the influence of any narcotic unless administered on the advice of a physician (not applicable in NM and VT).

Monthly Operating Expense Benefits

When injuries or sickness results in total loss of time, we will pay benefits for operating expenses you incur during such total loss of time. Benefits are subject to the deductible (or elimination) period. Benefits for operating expenses incurred each month will be paid up to the average monthly (in PA, the maximum) operating expenses for the 12-month period immediately before the start of the total loss of time. Benefits are limited to the Maximum Monthly Benefit, but not to exceed in the aggregate, the Maximum Operating Expense Benefit for one accident or sickness.

In MA, PA, SC & VA, if benefits are payable for less than one month, the benefit payable for each day will be 1/30th of the average monthly operating expense as determined above. In TN, a pro rata benefit will be paid for a loss of less than one month.

A pro rata benefit will be paid for a loss of less than one month (TN only).

In the event that your average monthly operating expense decreases, the monthly benefits of your policy will be continued during a period of total loss of time until the Maximum Operating Expense Benefit is paid (not applicable in PA).

In NC, upon your written request, the Maximum Monthly Benefit may be increased. The increase will be effective on the first day of the calendar month following the date we receive your request and evidence of insurability. This adjustment cannot exceed the amount nearest your monthly office operating expense reported. A corresponding premium adjustment will also be made.

Operating Expenses

Operating Expenses include: rent; electricity, heat, water and other utilities; telephone; laundry; accountant's service; salaries of employees; taxes; depreciation on office equipment; deterioration of supplies; payments of interest on business debts but not principal; postage and stationery; monthly prorate of annual charitable contributions; telephone answering service; prorate of business insurance premiums; membership fees and dues for professional and business societies or associations; subscription charges for business or professional periodicals; maintenance service and such other fixed expenses as are normal and customary in the conduct and operation of your office or business. In the event of joint occupancy or partnership, only your portion of such expenses is covered.

Operating expenses do not include: your salary; fees; drawing accounts or any other compensation received by you nor the cost of goods; wares; pharmaceutical products or professional books; equipment or other items not specifically named in your policy.

Other Features of Your Plan

Conversion Privilege

Regardless of changes in your health, upon your written request for conversion of the policy, the Company agrees to issue an individual loss of time policy to replace this coverage.Written request must be submitted prior to the Insured's 60th birthday, and the Insured must then be regularly and gainfully employed on a full-time basis.

Waiver of Premium

The Company will waive premiums on the policy after total loss of time benefits have been paid continuously for three months. This waiver applies only to those premiums becoming due after such three-month period.

Contains a Recurrent Provision

In the event of further total loss of time as a result of sickness or injuries for which benefits have been payable, the Maximum Operating Expense Benefit and Deductible Period will be restored after the Insured returns to work on a full-time basis for a period of six consecutive months.

Grace Period

A grace period of 31 days will be granted for the payment of renewal premiums.

This is a brief description of some of the important features and benefits of this Business Operating Expense Policy. Additional information may be found in the brochure.

However, the policy itself details the rights and obligations of both you and Mutual of Omaha Insurance Company. PLEASE READ YOUR POLICY CAREFULLY.

Policy Form 150BE (in ID, Form 150BE Series-10116; in OK, Form 150BE Series-8972; in OR, Form 150BE Series-13316; in PA, Form 150BE Series-10501; in TX, Form 150BE Series-9068) or state equivalent.

Underwritten by: Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha, Nebraska 68175, 402 342 7600

Guidelines When Considering Immigrants and Non-Immigrants for Insurance Coverage

Acceptable Immigrant Status For Consideration of Life and/or Health Insurance Coverage. An individual with a valid Alien Registration Receipt Card (also know in layman's term as a "Green Card") will be eligible to apply for such coverage. In addition, the individual must meet all four requirements listed below:

1. Reside in the United States for a minimum of 12 consecutive months to apply for life insurance coverage and 36 consecutive months to apply for health insurance coverage.

2. Have a minimum net annual income of $20,000 from U.S. based assets or entitlement benefits (i.e., social security or pension benefits) or U.S. based employment.

3. Show intent to reside permanently in the United States. Some examples of this intent are:
   - Own a home in the United States,
   - Own business in the United States, and/or,
   - Have child or children who are United States citizens and who reside in the United States.

4. Complete the Foreign Travel Questionnaire (L5719_1103).

Unacceptable Non-Immigrant Visas. Except as otherwise noted below, individuals who have the following temporary visas WILL NOT be considered for life and/or health insurance coverage:

A-1	D-2	H-1C	L-2*	P-4
A-2	E1	H-2A	M-1	Q-1
A-3	E2	H-2B*	M-2	Q-3
B-1	F1	H-3	N-8	R-1
B-2	F2	H-4	N-9	R-2
C-1	G1	J-1	O-1	S-5
C-1D	G2	J-2	O-2	S-6
C-2	G3	K-1	O-3	
C-3	G4	K-2	P-1	
C-4	G5	L-1A*	P-2	
D-1	H-1B*	L-1B*	P-3	

We will also not consider individuals who reside in the United State because of their receipt of a Political Asylum or Humanitarian Asylum Visa.

Note: Some individuals who have a valid H-1B, H-2B, L-1A, L-1B, or L-2 visa may be considered for life and/or health insurance coverage. The producer must contact Life Underwriting and/or Health Underwriting, as applicable, to discuss the case and obtain the applicable underwriting approval before completing an application.

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza, Omaha, NE 68175, 402-342-7600

Long-Term Disability Income Insurance Coverage – Outline of Coverage

For Policy Form D81-20949 and D81-20950

Read Your Policy Carefully

This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Disability Income Insurance Coverage

Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

Total Disability Benefits

If you are Totally Disabled because of a Sickness or Injury, we will pay the Total Disability Monthly Benefit. Total Disability benefits begin after the Elimination Period has been satisfied. Benefits are payable while you remain Totally Disabled for as long as the Benefit Period.

Proportionate Disability Benefits

If you are Proportionately Disabled because of Sickness or Injury and incur a 20% or greater Loss of Monthly Income, we will pay a percentage of your Total Disability Monthly Benefit that is proportionate to your lost income.

Presumptive Total Disability Benefits

We will automatically pay Total Disability Benefits under your policy and any Social Insurance Supplement Benefits Rider for the full length of the Benefit Period upon proof of your presumptive Total Disability. Benefits are payable even if you return to work at any occupation. The Elimination Period will be waived. Regular Medical Care will not be required. You will be presumed to be permanently Totally Disabled if Sickness or Injury results in the complete and irrecoverable loss of your:

(a) speech;
(b) hearing in both ears;
(c) sight in both eyes; or
(d) the use of both hands, both feet or one hand and one foot.

Transplant Donor Benefits

If you become Totally Disabled or Proportionately Disabled as the result of a transplant of part of your body to the body of another person, we will pay benefits under your policy and any Social Insurance Supplement Benefits Rider on the same basis as any other Sickness.

Terminal Illness Benefit

If you are diagnosed with a Terminal Illness, you can elect to receive an accelerated payment of the remaining Total Disability Monthly Benefits due in a lump sum amount. This Terminal Illness Benefit may accelerate up to 12 months of the current benefits payable under your policy and any Social Insurance Supplement Benefits Rider.

Survivor Benefit

Upon your death, we will pay a Survivor Benefit to your designated Beneficiary, if Total or Proportionate Disability benefits were payable; and the Benefit Period was not exhausted.

Rehabilitation Benefit

While you are receiving Total Disability or Proportionate Disability benefits, we may pay for a vocational rehabilitation program.

Guaranteed Renewable to Age 67, Conditionally Renewable Thereafter to Age 75

You are guaranteed the right to continue your coverage until Age 67. During that time, we cannot cancel your policy as long as you pay the required premium when it is due. After Age 67, you may continue your coverage to Age 75 provided you maintain Full-Time Employment and pay the necessary premium when due.

Premium Changes

Your policy's premium may change before Age 67, but only if the same change is made to all policies of this form issued to persons of the same Class. After Age 67, the premium will increase every year because the premium rate is then based upon your attained age. The premium may also change for other reasons after Age 67, but only if we make the same change on a Class basis. We will give you at least 45 days advance written notice before any premium change. In no event will the premium increase during the first 12 months following the Policy Date.

Exclusions and Limitations

Benefits are not payable for:

(a) loss that begins while this policy is not in force;

(b) loss resulting from an act of declared or undeclared war;

(c) loss sustained while serving in the armed forces (upon notice to us of entry into the armed forces, the unearned portion of the premium will be refunded);

(d) loss caused by intentionally self-inflicted injury (while sane in Colorado);

(e) loss resulting from commission or attempted commission of a felony;

(f) loss caused by suicide or attempted suicide, while sane or insane (sane only in Colorado and Missouri); or

(g) loss resulting from your being legally intoxicated or under the influence of an illegal substance or a narcotic (except for narcotics given on the advice of and taken as prescribed by a Physician).

Pregnancy

Benefits are not payable for loss due to Normal Childbirth, Normal Pregnancy or voluntarily induced abortion. We will pay benefits for Complications of Pregnancy on the same basis as any other Sickness.

Substance Abuse Limitation

Benefits payable for Substance Abuse are limited to a lifetime maximum of 24 months.

Mental or Nervous Disorder Limitation

Benefits payable for Mental or Nervous Disorders are limited to a lifetime maximum of 24 months.

Benefits Reduction When Association Group Membership or Self-Employment Ends

(Policy Form D81-20950 Only)

This policy form was issued to you because you are self-employed or a member of a franchise/ association group. If your franchise/association membership ends, the organization ceases to endorse this product, or you stop being self-employed, you may continue this coverage. Premiums will not increase as a result of this change. However, all benefits payable for loss beginning after such time will be reduced by 15%.

Accident-Only Short-Term Disability Income Insurance Coverage – Outline of Coverage

This Policy Covers Accidents Only
It Does Not Pay Benefits For Loss Resulting From Sickness

For Policy Form D83-20900 and D83-20901

Read Your Policy Carefully

This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Accident Disability Income Insurance Coverage

Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident ONLY, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

Total Disability Benefits

If you are Totally Disabled because of an injury, we will pay the Total Disability Monthly Benefit. Total Disability benefits begin after the Elimination Period has been satisfied. Benefits are payable while you remain Totally Disabled for as long as the Benefit Period.

Partial Disability Benefits

If you are Partially Disabled because of an Injury, we will pay 50% of the Total Disability Monthly Benefit. Partial Disability benefits begin after the Elimination Period has been satisfied. Benefits are payable while you remain Partially Disabled for the lesser of six months or the balance of the Benefit Period.

Presumptive Total Disability Benefits

We will automatically pay Total Disability Benefits for the full length of the Benefit Period upon proof of your presumptive Total Disability. Benefits are payable even if you return to work at any occupation. The Elimination Period will be waived. Regular Medical Care will not be required. You will be presumed to be permanently Totally Disabled if an Injury results in the complete and irrecoverable loss of your:

(a) speech;
(b) hearing in both ears;
(c) sight in both eyes; or
(d) the use of both hands, both feet or one hand and one foot.

Survivor Benefit

Upon your death, we will pay a survivor benefit to your designated Beneficiary, if Total or Proportionate Disability benefits were payable; and the Benefit Period was not exhausted.

Guaranteed Renewable to Age 67

You are guaranteed the right to continue your coverage until Age 67. During that time, we cannot cancel your policy as long as you pay the required premium when it is due.

Premium Changes

Your policy's premium may change, but only if the same change is made to all policies of this form issued to persons of the same Class. We will give you at least 45 days advance written notice before any premium change. In no event will the premium increase during the first 12 months following the Policy Date.

Exclusions

We will not pay benefits for:

(a) loss that begins while this policy is not in force;

(b) loss resulting from an act of declared or undeclared war;

(c) loss sustained while serving in the armed forces (upon notice to us of entry into the armed forces, the unearned portion of the premium will be refunded);

(d) loss caused by intentionally self-inflicted injury (while sane in Colorado);

(e) loss resulting from commission or attempted commission of a felony;

(f) loss caused by suicide or attempted suicide, while sane or insane (sane only in Colorado and Missouri);

(g) loss resulting from your being legally intoxicated or under the influence of an illegal substance or a narcotic (except for narcotics given on the advice of and taken as prescribed by a Physician); or

(h) loss resulting directly or indirectly from disease or bodily infirmity;

Benefits Reduction When Association Group Membership or Self-Employment Ends

(Policy Form D83-20901 Only)

This policy form was issued to you because you are self-employed or a member of a franchise/association group. If your franchise/association membership ends, the organization ceases to endorse this product, or you stop being self-employed, you may continue this coverage. Premiums will not increase as a result of this change. However, all benefits payable for loss beginning after such time will be reduced by 15%.

Workers' Compensation Limitation

Benefits payable for loss for which benefits are provided under any state or federal workers' compensation, employer's liability, or occupational disease law will be reduced by 50%.

MUTUAL OF OMAHA INSURANCE COMPANY
Mutual of Omaha Plaza, Omaha, NE 68175, 402-342-7600

SHORT-TERM DISABILITY INCOME INSURANCE – OUTLINE OF COVERAGE

For Policy Form D82-20898 and D82-20899

READ YOUR POLICY CAREFULLY

This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

DISABILITY INCOME INSURANCE COVERAGE

Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

TOTAL DISABILITY BENEFITS

If you are Totally Disabled because of a Sickness or Injury, we will pay the Total Disability Monthly Benefit. Total Disability benefits begin after the Elimination Period has been satisfied. Benefits are payable while you remain Totally Disabled for as long as the Benefit Period.

PARTIAL DISABILITY BENEFITS

If you are partially disabled because of a Sickness or Injury, we will pay 50% of the Total Disability Monthly Benefit. Partial Disability benefits begin after the Elimination Period has been satisfied. Benefits are payable while you remain Partially Disabled for the lesser of six months or the balance of the Benefit Period.

PRESUMPTIVE TOTAL DISABILITY BENEFITS

We will automatically pay Total Disability Benefits for the full length of the Benefit Period upon proof of your presumptive Total Disability. Benefits are payable even if you return to work at any occupation. The Elimination Period will be waived. Regular Medical Care will not be required. You will be presumed to be permanently Totally Disabled if Sickness or Injury results in the complete and irrecoverable loss of your:

(a) speech;
(b) hearing in both ears;
(c) sight in both eyes; or
(d) the use of both hands, both feet or one hand and one foot.

TRANSPLANT DONOR BENEFITS

If you become Totally Disabled or Partially Disabled as the result of a transplant of part of your body to the body of another person, we will pay benefits on the same basis as any other Sickness.

TERMINAL ILLNESS BENEFIT

If you are diagnosed with a Terminal Illness, you can elect to receive an accelerated payment of the remaining Total Disability Monthly Benefits due in a lump sum amount. This Terminal Illness Benefit may accelerate up to 12 months of the current benefits payable under your policy.

SURVIVOR BENEFIT

Upon your death, we will pay a survivor benefit to your designated Beneficiary, if Total or Proportionate Disability benefits were payable; and the Benefit Period was not exhausted.

Rehabilitation Benefit

While you are receiving Total Disability or Partial Disability benefits, we may pay for a vocational rehabilitation program.

Guaranteed Renewable to Age 67, Conditionally Renewable Thereafter to Age 75

You are guaranteed the right to continue your coverage until Age 67. During that time, we cannot cancel your policy as long as you pay the required premium when it is due. After Age 67, you may continue your coverage to Age 75 provided you maintain Full-Time Employment and pay the necessary premium when due.

Premium Changes

Your policy's premium may change before Age 67, but only if the same change is made to all policies of this form issued to persons of the same Class. After Age 67, the premium will increase every year because the premium rate is then based upon your attained age. The premium may also change for other reasons after Age 67, but only if we make the same change on a Class basis. We will give you at least 45 days advance written notice before any premium change. In no event will the premium increase during the first 12 months following the Policy Date.

Exclusions and Limitations

We will not pay benefits for:

(a) loss that begins while this policy is not in force;

(b) loss resulting from an act of declared or undeclared war;

(c) loss sustained while serving in the armed forces (upon notice to us of entry into the armed forces, the unearned portion of the premium will be refunded);

(d) loss caused by intentionally self-inflicted injury (while sane in Colorado);

(e) loss resulting from commission or attempted commission of a felony;

(f) loss caused by suicide or attempted suicide, while sane or insane (sane only in Colorado and Missouri);

(g) loss resulting from your being legally intoxicated or under the influence of an illegal substance or a narcotic (except for narcotics given on the advice of and taken as prescribed by a Physician);

(h) loss resulting from substance abuse; or

(i) loss resulting from mental or nervous disorders.

Pregnancy

Benefits are not payable for loss due to Normal Childbirth, Normal Pregnancy or voluntarily induced abortion. We will pay benefits for Complications of Pregnancy on the same basis as any other Sickness.

Benefit Reduction When Association Group Membership or Self-Employment Ends

(Policy Form D82-20899 Only)

This policy form was issued to you because you are self-employed or a member of a franchise/association group. If your franchise/association membership ends, the organization ceases to endorse this product, or you stop being self-employed, you may continue this coverage. Premiums will not increase as a result of this change. However, all benefits payable for loss beginning after such time will be reduced by 15%.

Workers' Compensation Limitation

Benefits payable for loss for which benefits are provided under any state or federal workers' compensation, employer's liability, or occupational disease law will be reduced by 50%.

Business Operating Expense Summary of Coverage

For Policy Form 150BE

This coverage provides benefits for the operating expense of a business or a practice when the owner/Insured is completely unable to engage in his or her occupation (in CT, IA & VA, unable to engage in substantial and material duties of his or her occupation) as a result of covered illness or injury, receives no earnings for performing other work or service and receives medical treatment. Benefits of your plan are as indicated in your policy.

Renewal Agreement

We will renew your policy each time you send us the premium until you reach age 65. However, the policy will terminate when you retire, sell your business, or discontinue your business or the practice of your business or profession.

Premium Change

Your premium cannot be changed unless we make the same change on all policies of this form (and series in AL) issued to persons of the same classification in your state. In SC, you will receive at least 31 days' notice of a premium change.

Accidental Death Benefit (Not available in SC)

An amount equal to the total annualized premium of the policy and all riders in effect on the date of a covered accident, multiplied by the number of full years the policy has been in force, will be paid when such injury results in the Insured's death within 90 days (180 days in UT) after the date of the accident. This benefit is paid in addition to any other benefit under the policy. If there is a change of Insured, the Policy Date for this provision will be the date such change takes effect (not applicable in TN). (In TN, the minimum benefit is $1,000).

In VA, benefit is payable if injuries you receive while the policy is in force cause your death within: (a) 90 days of the accident or (b) 12 months of the accident if, as a result of the accident, you suffered continuous total disability that began within 30 days of the accident. The benefit is an amount equal to the total annualized premium of the policy and all riders in effect on the date of the accident, multiplied by the number of full years the policy has been in force. It is payable in addition to any other benefit. The minimum benefit is $1,000.00. If there is a change of Insured, the Policy Date, for this provision will be the date such change takes effect. Benefits are not payable for loss caused by suicide while sane or insane, an act of declared or undeclared war or sustained while in an armed service.

Tax Deductible

Your Business Operating Expense Policy has been designed to meet the requirements of Internal Revenue Service rulings which allow certain business professionals who are sole proprietors, partners and stockholders/employees of a business to use premiums for the policy as direct business expense for tax deduction. This is based on current tax code.

Preexisting Sickness or Injury (Not applicable in PA)

Means a sickness or injury which first makes itself known or is medically treated before the Policy Date and which must be disclosed as requested on the application. In MA, a sickness or injury makes itself known when the symptoms are clear enough to cause a prudent person to seek medical attention. Benefits are payable for such preexisting sickness or injuries made known to us on the application and not excluded from coverage. Benefits for such conditions shown on the policy Schedule will be payable only for such loss which starts after the policy has been in force at least 12 months. In AR, a sickness or injury for which medical advice or treatment was recommended by or received from a physician within five years from the Policy Date and which must be disclosed as requested on the application. Benefits are payable for such preexisting sickness or injuries made known to us on the application and not excluded from coverage. Benefits for such conditions shown on the policy Schedule will be payable only for such loss which starts after the policy has been in force at least 12 months.

In CT, IA & WA, benefits will not be payable for loss caused by any condition, which makes itself known during the five-year period prior to the date the person suffering the loss became insured. A condition will be considered to have made itself known when medical care or treatment has been given, or there exist symptoms which could cause an ordinarily prudent person to seek diagnosis, care or treatment. In CT, this provision does not affect our rights with respect to any material misrepresentations contained in the application.

In VA, Subject to the Time Limit on Certain Defenses provision, benefits are not payable under the policy for loss caused by any condition which makes itself known during the two-year period prior to the Policy Date. A condition will be considered to have made itself known when: (1) medical advice or treatment has been received from a physician; or (2) there exist symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment.

Exceptions

Benefits are not payable for: (a) loss beginning while the policy is not in force; (b) loss resulting from suicide while sane or insane (in MO, while sane only); (c) loss resulting from air

travel unless sustained while a passenger (not as a pilot or member of the crew) for transportation only; (d) loss caused by an act of declared or undeclared war; (e) loss sustained while in an armed service (upon notice to the Company of entry into such service, the pro rata premium will be refunded); (f) normal childbirth, normal pregnancy or voluntarily induced abortion; or in MN childbirth or pregnancy; (g) in AR, loss resulting from certain pregnancy related conditions; (h) in KS, NH, PR and WA, childbirth, pregnancy or complications resulting therefrom; (l) in MN, alcoholism, drug addition or drug dependence.

In CO, FL, ID, MN, NC & UT, benefits are payable for complications of pregnancy on the same basis as any other covered sickness.

In MT & UT, subject to all policy provisions and limitations, maternity is payable on the same basis as any other sickness.

We will not be liable for any loss that results from being under the influence of any narcotic unless administered on the advice of a physician (not applicable in NM and VT).

Monthly Operating Expense Benefits

When injuries or sickness results in total loss of time, we will pay benefits for operating expenses you incur during such total loss of time. Benefits are subject to the deductible (or elimination) period. Benefits for operating expenses incurred each month will be paid up to the average monthly (in PA, the maximum) operating expenses for the 12-month period immediately before the start of the total loss of time. Benefits are limited to the Maximum Monthly Benefit, but not to exceed in the aggregate, the Maximum Operating Expense Benefit for one accident or sickness.

In MA, PA, SC & VA, if benefits are payable for less than one month, the benefit payable for each day will be 1/30th of the average monthly operating expense as determined above. In TN, a pro rata benefit will be paid for a loss of less than one month.

A pro rata benefit will be paid for a loss of less than one month (TN only).

In the event that your average monthly operating expense decreases, the monthly benefits of your policy will be continued during a period of total loss of time until the Maximum Operating Expense Benefit is paid (not applicable in PA).

In NC, upon your written request, the Maximum Monthly Benefit may be increased. The increase will be effective on the first day of the calendar month following the date we receive your request and evidence of insurability. This adjustment cannot exceed the amount nearest your monthly office operating expense reported. A corresponding premium adjustment will also be made.

Operating Expenses

Operating Expenses include: rent; electricity, heat, water and other utilities; telephone; laundry; accountant's service; salaries of employees; taxes; depreciation on office equipment; deterioration of supplies; payments of interest on business debts but not principal; postage and stationery; monthly prorate of annual charitable contributions; telephone answering service; prorate of business insurance premiums; membership fees and dues for professional and business societies or associations; subscription charges for business or professional periodicals; maintenance service and such other fixed expenses as are normal and customary in the conduct and operation of your office or business. In the event of joint occupancy or partnership, only your portion of such expenses is covered.

Operating expenses do not include: your salary; fees; drawing accounts or any other compensation received by you nor the cost of goods; wares; pharmaceutical products or professional books; equipment or other items not specifically named in your policy.

Other Features of Your Plan

Conversion Privilege

Regardless of changes in your health, upon your written request for conversion of the policy, the Company agrees to issue an individual loss of time policy to replace this coverage.Written request must be submitted prior to the Insured's 60th birthday, and the Insured must then be regularly and gainfully employed on a full-time basis.

Waiver of Premium

The Company will waive premiums on the policy after total loss of time benefits have been paid continuously for three months. This waiver applies only to those premiums becoming due after such three-month period.

Contains a Recurrent Provision

In the event of further total loss of time as a result of sickness or injuries for which benefits have been payable, the Maximum Operating Expense Benefit and Deductible Period will be restored after the Insured returns to work on a full-time basis for a period of six consecutive months.

Grace Period

A grace period of 31 days will be granted for the payment of renewal premiums.

This is a brief description of some of the important features and benefits of this Business Operating Expense Policy. Additional information may be found in the brochure.

However, the policy itself details the rights and obligations of both you and Mutual of Omaha Insurance Company. PLEASE READ YOUR POLICY CAREFULLY.

Policy Form 150BE (in ID, Form 150BE Series-10116; in OK, Form 150BE Series-8972; in OR, Form 150BE Series-13316; in PA, Form 150BE Series-10501; in TX, Form 150BE Series-9068) or state equivalent.

Underwritten by: Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha, Nebraska 68175, 402 342 7600